

J U N E 2 0 0 4

A DATA BOOK

Healthcare Spending
and the
Medicare Program

Introduction

MedPAC's Data Book is the result of discussions with Congressional staff regarding ways that MedPAC can better support them. The 2004 edition is a follow up to last year's first publication. It contains the type of information that MedPAC provides in publications like the March or June reports; it also combines data from other sources, such as CMS. The format is condensed into tables and figures with brief discussion. Web site links to MedPAC publications or other websites are included after the table or figure, or on a "Web links" page at the end of each section.

- The first sections detail Medicare beneficiary demographics, dual eligible beneficiaries, quality and access in the Medicare program, Medicare beneficiary and other payer liability, and national health care and Medicare spending.
- The next sections examine provider settings—such as hospitals or post-acute care—and present data on Medicare spending, percent of beneficiaries using the service, number of providers, volume, and margins, if applicable.
- The final sections cover Medicare Advantage and the availability of other supplemental options for Medicare beneficiaries, and prescription drug coverage for Medicare beneficiaries.

Limited printed copies are being distributed. This report is, however, available through the MedPAC website: www.medpac.gov.

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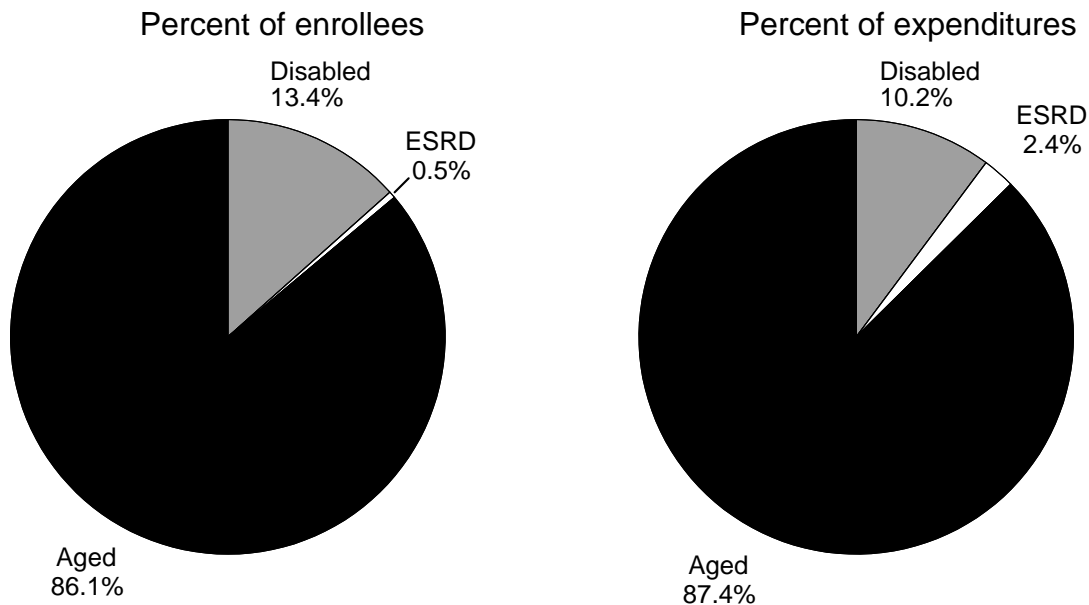
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S E C T I O N

1

Medicare beneficiary demographics

Chart 1-1. Aged beneficiaries account for the greatest share of the Medicare population and program spending, 2001

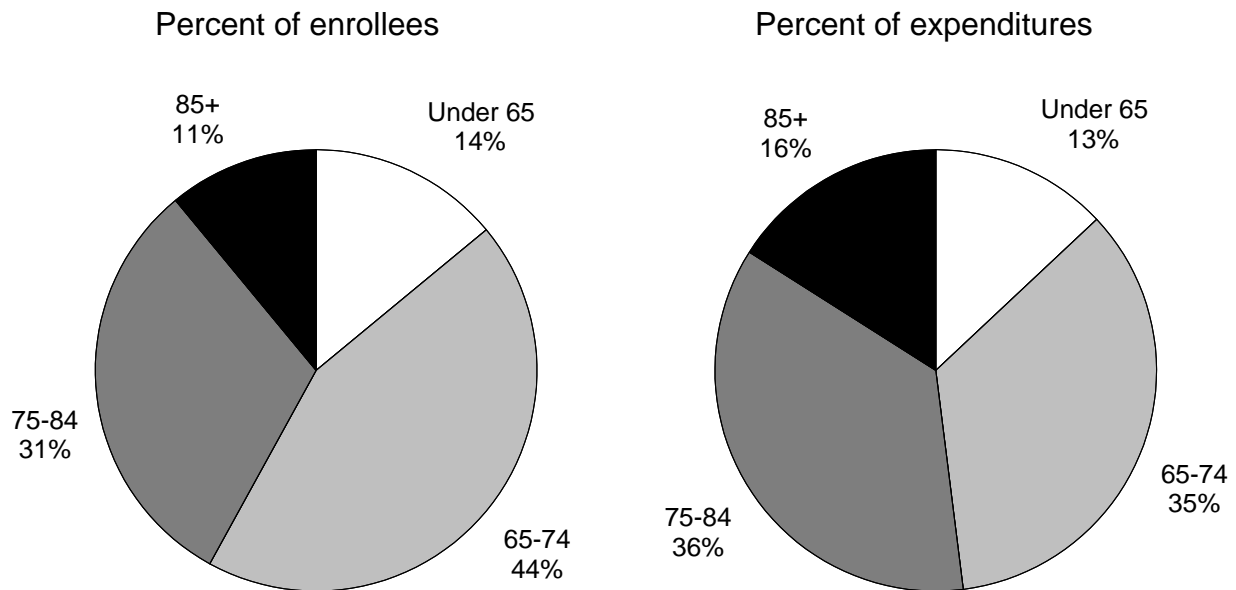


Note: ESRD (end-stage renal disease) refers to beneficiaries under age 65 with ESRD. The disabled category refers to beneficiaries under age 65 without ESRD. The aged category refers to beneficiaries age 65 and older.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2001.

- Reflecting their greater share of the Medicare population, the highest percentage of Medicare expenditures is for aged beneficiaries.
- A disproportionate share of Medicare expenditures is spent on Medicare beneficiaries who are eligible due to end-stage renal disease (ESRD). On average, ESRD beneficiaries cost at least 5 times as much as beneficiaries in other categories: \$5,961 is spent per aged beneficiary, \$4,462 per (non-ESRD) disabled beneficiary, and \$29,399 per ESRD beneficiary. On average, Medicare spending per beneficiary is \$5,875.

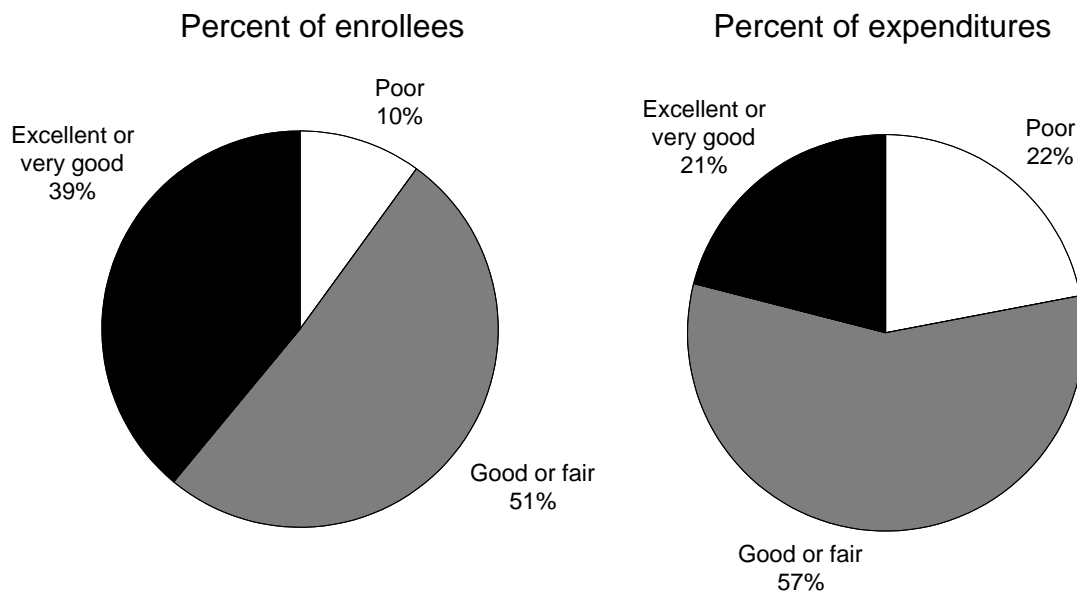
Chart 1-2. Medicare spending rises as beneficiaries age, 2001



Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2001.

- Per capita expenditures increased by about \$2,000 for each age group over 65: Per capita expenditures were \$4,685 for those ages 65 to 74, \$6,855 for those 75 to 84, and \$8,413 for those 85 and older. Per capita expenditures for Medicare beneficiaries under age 65, enrolled due to disability (both end-stage renal disease and non-ESRD), were \$5,342. On average, Medicare spending per beneficiary was \$5,875.

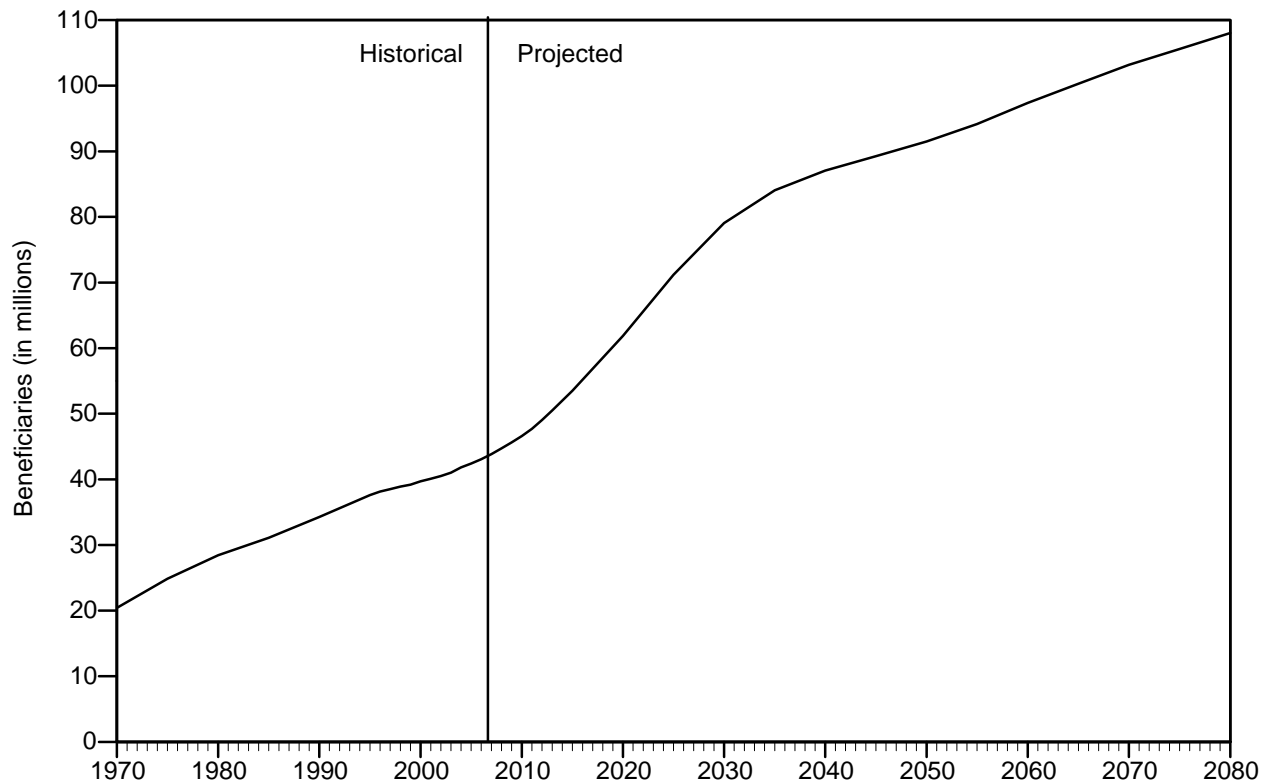
Chart 1-3. Beneficiaries who report being in poor health account for a disproportionate share of Medicare spending, 2001



Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2001.

- Medicare spending is strongly associated with self-reported health status. Per capita expenditures for those with excellent health are \$3,197; \$6,493 for those with good or fair health; and \$13,139 for those with poor health. On average, Medicare spending per beneficiary is \$5,875.

Chart 1-4. Enrollment in the Medicare program is projected to grow fastest in the next 30 years



Source: MedPAC analysis of the Social Security Administration 2004 Trustees Report, Intermediate Assumptions.

- The total number of people enrolled in the Medicare program will nearly double between 2000 and 2030, from about 40 million to 79 million beneficiaries.
- The rate of increase in Medicare enrollment accelerates around 2010 when members of the “baby boom” population start to become eligible and slows around 2030 when the entire baby boom population has become eligible.

Chart 1-5. Characteristics of the Medicare population, 2001

Characteristic	Percent of the Medicare population
Total (41,216,778*)	100%
Sex	
Male	44
Female	56
Race/ethnicity	
White, non-Hispanic	80
African American, non-Hispanic	9
Hispanic	7
Other	4
Age	
< 65	14
65–74	44
75–84	31
85+	11
Health status	
Excellent or very good	39
Good or fair	51
Poor	10
Residence	
Urban	76
Rural	24
Living arrangement	
Institution	6
Alone	28
Spouse	49
Other	16
Education	
No high school diploma	33
High school diploma only	30
Some college or more	37
Income status	
Below poverty	17
100–125% of poverty	11
125–200% of poverty	22
200–400% of poverty	33
Over 400% of poverty	18
Supplemental insurance status	
Medicare only	10
Managed care	16
Employer	31
Medigap	22
Medigap/employer	4
Medicaid	15
Other	2

Note: Urban indicates beneficiaries living in metropolitan statistical areas (MSAs). Rural indicates beneficiaries living outside MSAs. In 2001, poverty was defined as \$8,494 for people living alone and as \$10,715 for married couples. Totals may not sum to 100 due to rounding.

*Based on a representative sample of the Medicare population.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2001.

- The Medicare population tends to be female, white, between the ages of 65 and 84, in good or fair health, and living with a spouse. Most beneficiaries live in urban areas and have graduated from high school and have some form of supplemental insurance coverage. Half have incomes under 200 percent of poverty.

Chart 1-6. Characteristics of the Medicare population, by rural and urban residence, 2001

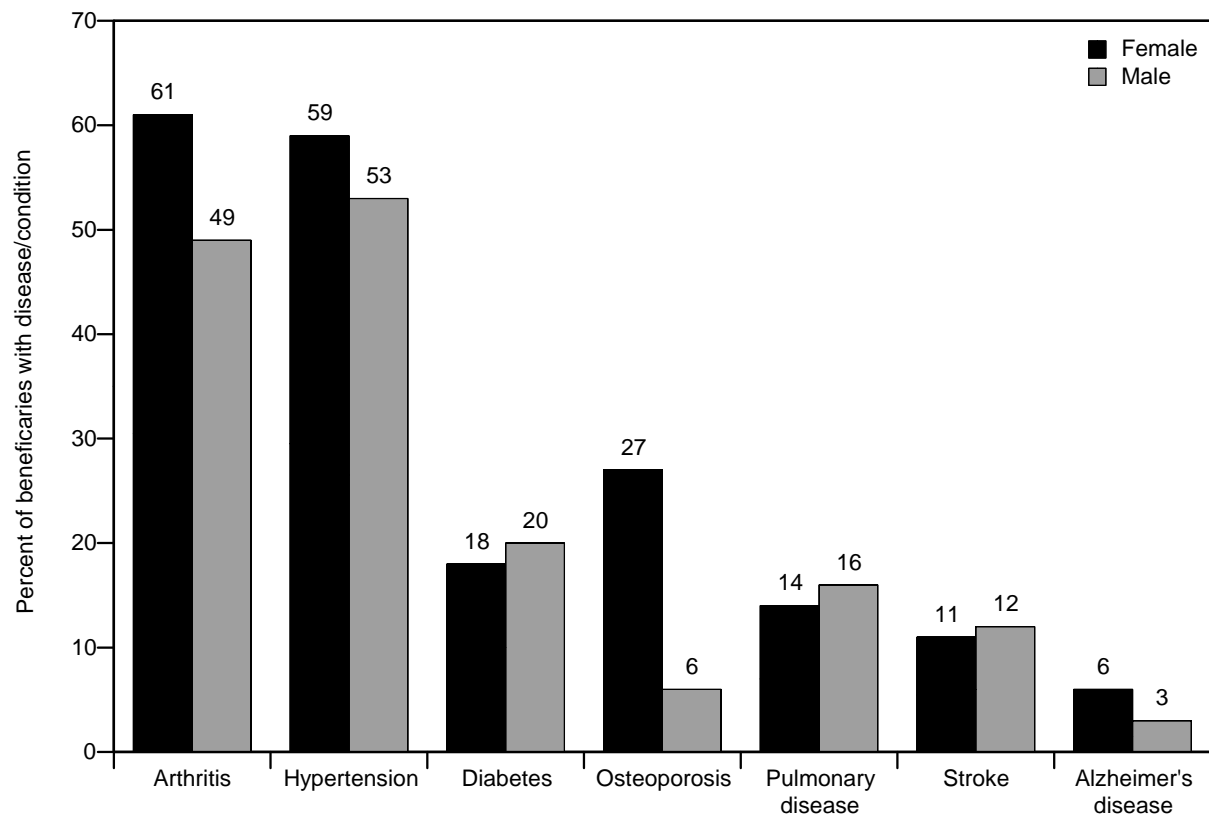
Characteristics	Percent of urban Medicare population	Percent of rural Medicare population
Total	100%	100%
Urban 76%		
Rural 24%		
Sex		
Male	43	45
Female	57	55
Race/ethnicity		
White, non-Hispanic	78	86
African American, non-Hispanic	10	8
Hispanic	8	3
Other	4	3
Age		
< 65	13	15
65–74	43	44
75–84	32	29
85+	11	12
Health status		
Excellent or very good	40	36
Good or fair	51	52
Poor	9	12
Income status		
Below poverty	15	20
100–125% of poverty	10	11
125–200% of poverty	22	23
200–400% of poverty	33	31
Over 400% of poverty	20	13

Note: Urban indicates beneficiaries living in metropolitan statistical areas (MSAs). Rural indicates beneficiaries living outside MSAs. In 2001, poverty was defined as \$8,494 for people living alone and as \$10,715 for married couples. Totals may not sum to 100 due to rounding.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2001.

- Close to one-fourth of all beneficiaries reside in rural areas.
- Rural Medicare beneficiaries are more likely to be white (86 vs. 78 percent), to report being in poor health (12 vs. 9 percent), and to have income below 125 percent of poverty (31 vs. 25 percent), compared to urban beneficiaries.

Chart 1-7. Arthritis and hypertension are the most common diseases reported by Medicare beneficiaries, 2001



Source: CMS, Office of Research, Development, and Information.

- Arthritis, hypertension, diabetes, osteoporosis, and pulmonary disease are among the most prevalent chronic conditions reported by Medicare beneficiaries.
- Female beneficiaries live longer, and the risk of chronic disease increases with age. Female beneficiaries are more likely than male beneficiaries to have arthritis, hypertension, osteoporosis, or Alzheimer's disease.

Web links. Medicare beneficiary demographics

- The CMS Chart series provides information on the Medicare program, including beneficiary demographics.

<http://www.cms.gov/charts>

- The CMS Data Compendium provides information on Medicare enrollment by state.

<http://www.cms.hhs.gov/researchers/pubs/datacompendium/current/>

- The CMS website provides information about the Medicare Current Beneficiary Survey, a resource on the demographic characteristics of Medicare beneficiaries.

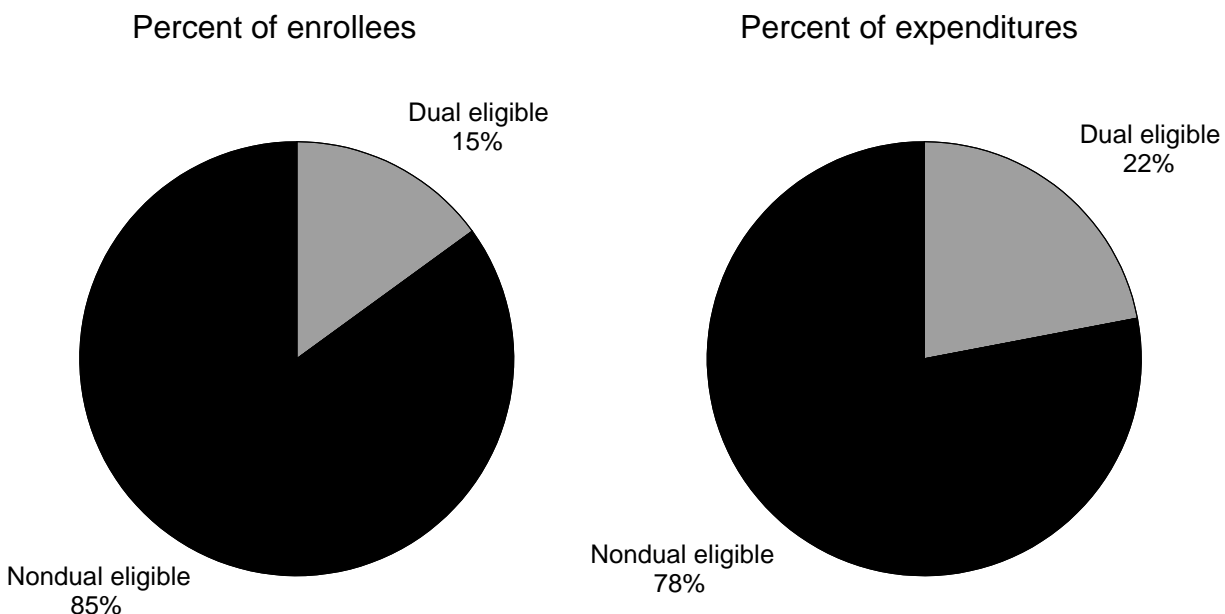
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SECTION

2

Dual eligible beneficiaries

Chart 2-1. Dual eligible beneficiaries account for a disproportionate share of Medicare spending, 2001

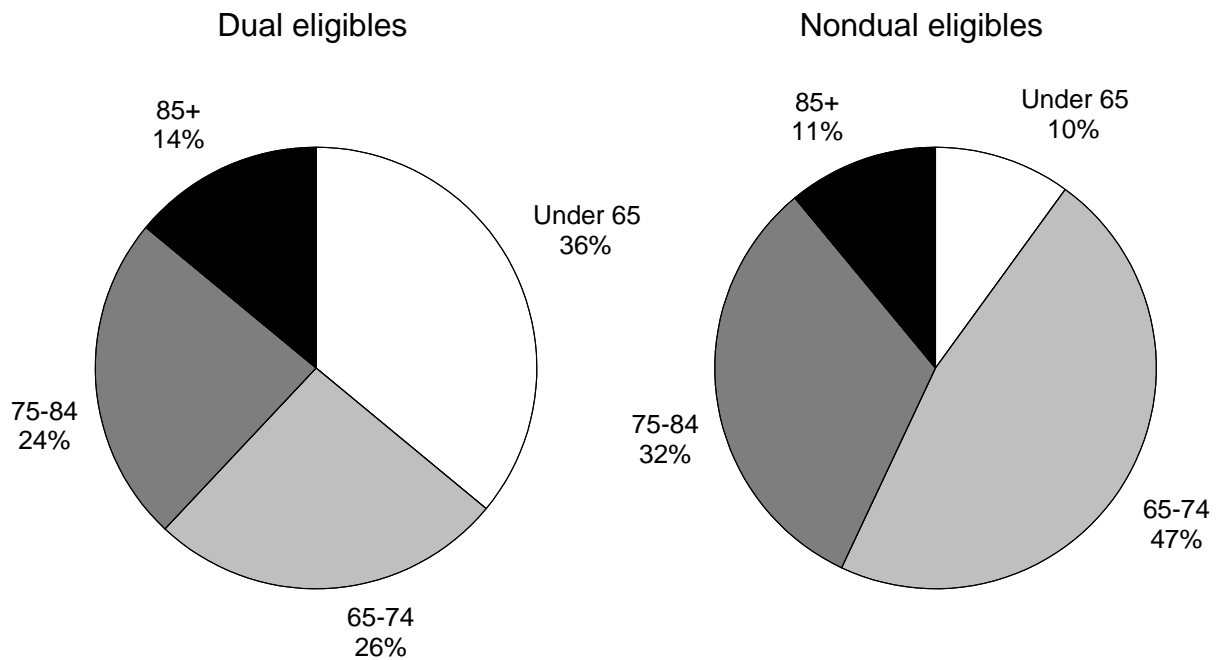


Note: Dual eligibles are designated as such if the months they qualify for Medicaid exceed months they qualify for other supplemental insurance.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2001.

- Dual eligible beneficiaries are those who qualify for both Medicare and Medicaid. Medicaid is a joint federal and state program designed to help low-income persons obtain needed healthcare. (More information on dual eligibles can be found in Chapter 3 of MedPAC's June 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/June03_Ch3.pdf.)
- A disproportionate share of Medicare expenditures is spent on dual eligible beneficiaries: Dual eligibles account for 15 to 17 percent of Medicare beneficiaries and 22 to 26 percent of Medicare spending (depending on the method used to determine dual eligibility).
- Dual eligibles cost Medicare about 1.5 times as much as nondual eligibles: \$8,559 is spent per dual eligible beneficiary, and \$5,399 is spent per nondual eligible beneficiary.
- Total spending—which includes spending by Medicare, Medicaid, supplemental insurance and out-of-pocket across all payers—for dual eligibles averaged about \$20,840 per person in 2001, more than twice the amount for other Medicare beneficiaries.

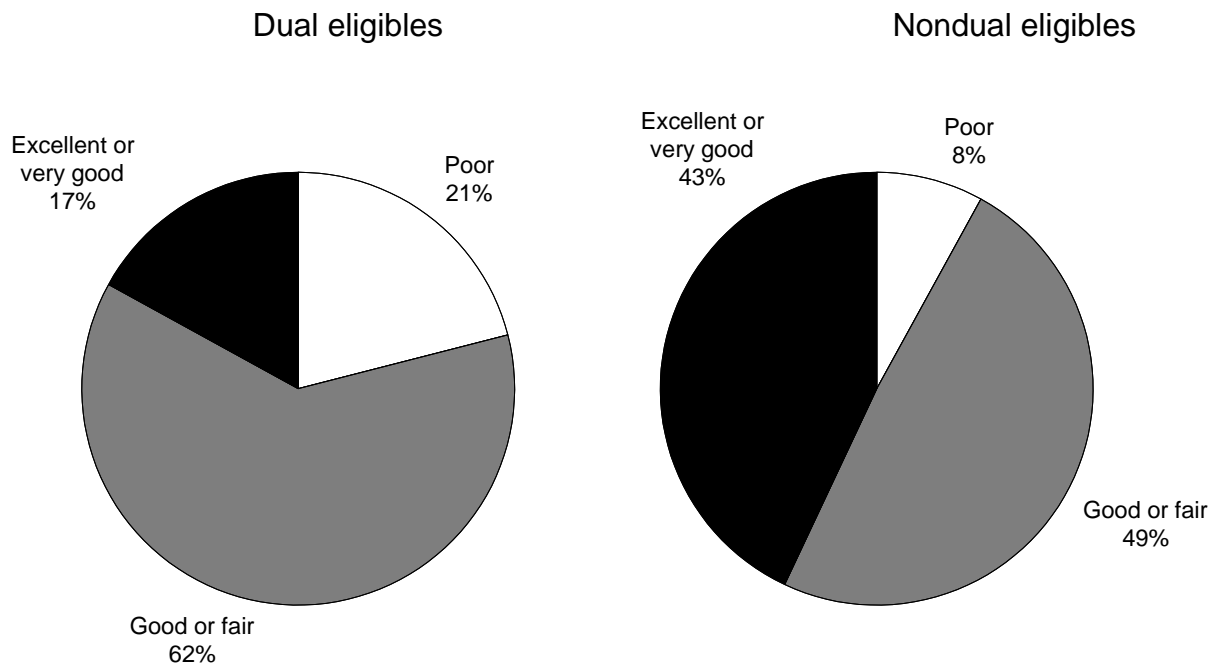
Chart 2-2. Dual eligibles are more likely than nondual eligibles to be disabled or over 85 years old, 2001



Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2001.

- More than one-third of dual eligibles qualify for Medicare because they are disabled (under 65), and 14 percent are age 85 or older—dual eligibles are three times more likely to be disabled than the nondual eligible population.

Chart 2-3. Dual eligibles are more likely than nondual eligibles to report poorer health status, 2001



Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2001.

- Relative to nondual eligibles, dual eligibles report poorer health status. The majority report good or fair status, but just over 20 percent of the dual eligible population report being in poor health (compared with less than 10 percent of the nondual eligible population).
- Dual eligibles are more likely to suffer from cognitive impairment and mental disorders, and they have higher rates of diabetes, pulmonary disease, stroke, and Alzheimer's disease than do nondual eligibles.
- Almost one-quarter of dual eligibles reside in an institution, compared with 3 percent of nondual eligibles.

Chart 2-4. Demographic differences between dual eligibles and nondual eligibles, 2001

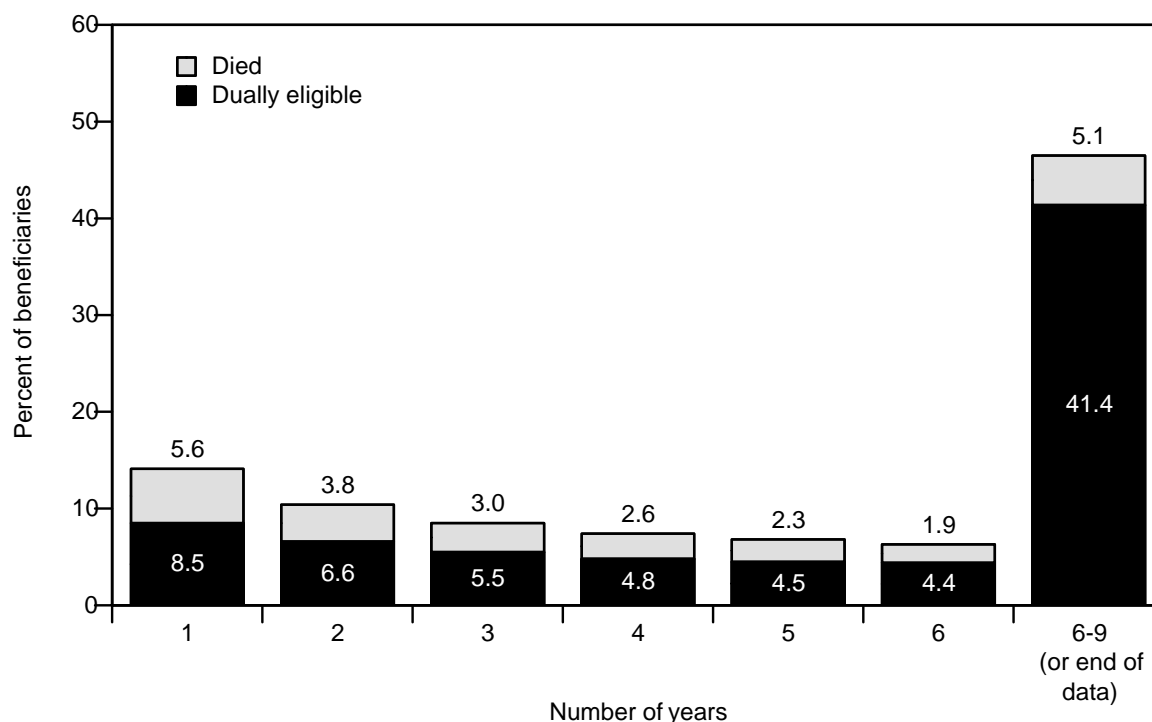
Characteristic	Percent of dual eligible beneficiaries	Percent of nondual eligible beneficiaries
Sex		
Male	38%	45%
Female	62	55
Race/ethnicity		
White, non-Hispanic	57	84
African American, non-Hispanic	21	7
Hispanic	15	6
Other	7	3
ADLs		
No ADLs	45	71
1–2 ADLs	22	19
3–6 ADLs	33	10
Residence		
Urban	73	77
Rural	27	23
Living arrangement		
Institution	23	3
Alone	31	28
Spouse	16	55
Children, nonrelatives, others	31	14
Education		
No high school diploma	62	28
High school diploma only	23	31
Some college or more	15	41
Income status		
Below poverty	62	9
100–125% of poverty	20	9
125–200% of poverty	12	24
200–400% of poverty	4	38
Over 400% of poverty	1	21
Supplemental insurance status		
Medicare or Medicare/Medicaid only	91	12
Medicare managed care	1	18
Employer	1	36
Medigap	1	26
Medigap/employer	0	5
Other*	7	2

Note: ADL (activity of daily living). Dual eligibles are designated as such if the months they qualify for Medicaid exceed the months they qualify for other supplemental insurance. Urban indicates beneficiaries living in metropolitan statistical areas (MSAs). Rural indicates beneficiaries living outside MSAs. In 2001, poverty was defined as \$8,494 for people living alone and \$10,715 for married couples. Totals may not sum to 100 due to rounding.
 *Includes public programs such as the Department of Veterans Affairs and state-sponsored drug plans.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2001.

- By definition, dual eligibles are poor: Over 60 percent live below the poverty level, and 94 percent live below 200 percent of poverty. Compared to nonduals, dual eligibles are more likely to: be female, African American or Hispanic; lack a high school diploma; have greater limitations in activities of daily living; reside in a rural area; and live in an institution, alone, or with persons other than a spouse.

Chart 2-5. Beneficiaries who first became dually eligible for Medicaid between 1994 and 1996 were often still dually eligible 7 to 9 years later



Note: Some beneficiaries likely remained dually eligible beyond the nine year time period we analyzed. This analysis does not include all medically needy dual eligibles because the data do not allow us to identify all of them.

Source: MedPAC analysis of 5 percent denominator files, 1993–2002, from CMS.

- Medicare beneficiaries tend to remain on Medicaid for relatively long periods of time. Of beneficiaries who became dually eligible between 1994 and 1996, nearly half (47 percent) remained dually eligible for more than six years.
- Only 14 percent of those who became dually eligible between 1994 and 1996 were dual eligibles for one year or less.

Chart 2-6. Differences in spending and service use between dual eligibles and nondual eligibles, 2001

Service	Dual eligible beneficiaries	Nondual eligible beneficiaries
Average Medicare payment for all beneficiaries		
Total Medicare payments	\$8,559	\$5,399
Inpatient hospital	3,974	2,486
Physician ^a	2,278	1,720
Outpatient hospital	965	523
Home health	338	241
Skilled nursing facility ^b	727	322
Hospice	199	98
Percent of beneficiaries using service		
Total Medicare payments	92.2%	89.1%
Inpatient hospital	26.8	15.3
Physician ^a	90.5	70.7
Outpatient hospital	71.6	51.7
Home health	8.0	5.5
Skilled nursing facility ^b	7.7	3.2
Hospice	2.5	1.3

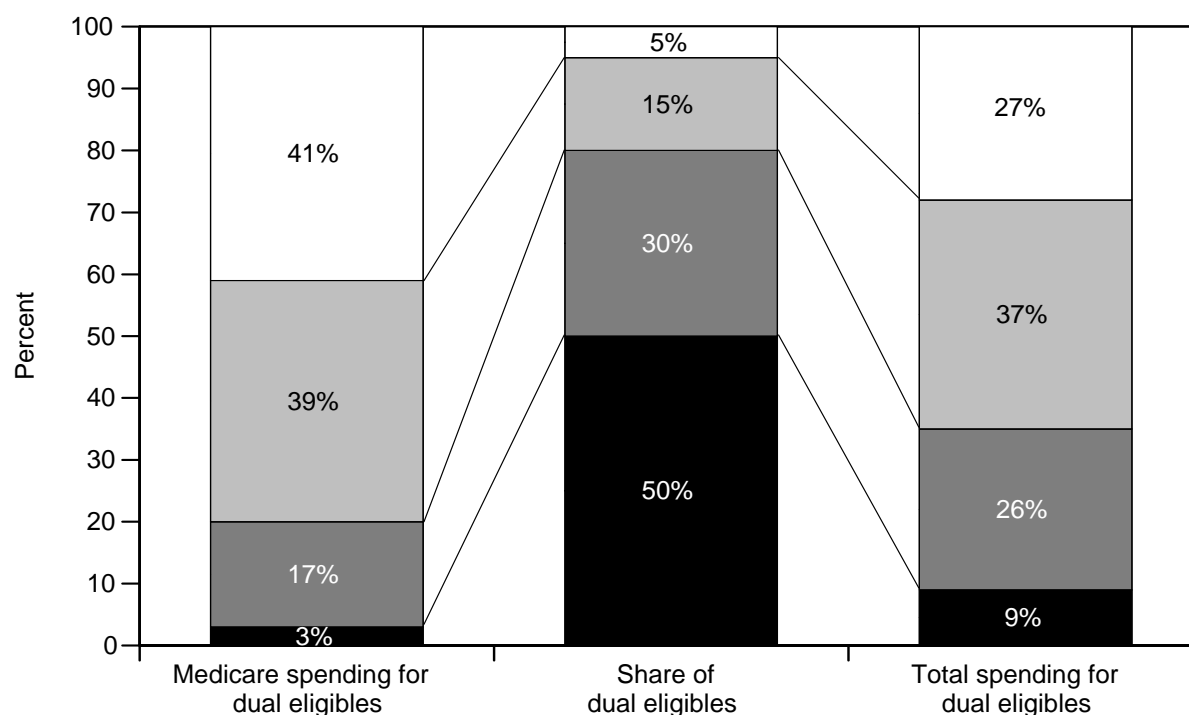
Note: ^aIncludes a variety of medical services, equipment, and supplies.

^bIndividual short-term facility (usually skilled nursing facility) stays for the Medicare Current Beneficiary Survey population.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2001, which updates the previous analysis by Liu et al. in 1998.

- Average per capita spending for dual eligibles is 59 percent higher than for nondual eligibles—\$8,559 compared to \$5,399.
- For each type of service, average Medicare per capita payments are higher for duals than nonduals. The largest percentage difference between the two groups is in skilled nursing facility (SNF) and hospice services, for which Medicare spends over twice as much on duals as on nonduals.
- Higher average per capita spending for duals is a function of both a higher proportion of duals using services than nonduals, as well as greater volume or intensity of use among those using services. A higher proportion of duals than nonduals use at least one Medicare-covered service, but the difference is relatively small—92 versus 89 percent.
- Duals are more likely to use each type of Medicare-covered service than nonduals; for example, duals are more than twice as likely to use SNF services.

Chart 2-7. Both Medicare and total spending are concentrated among dual eligible beneficiaries, 2001

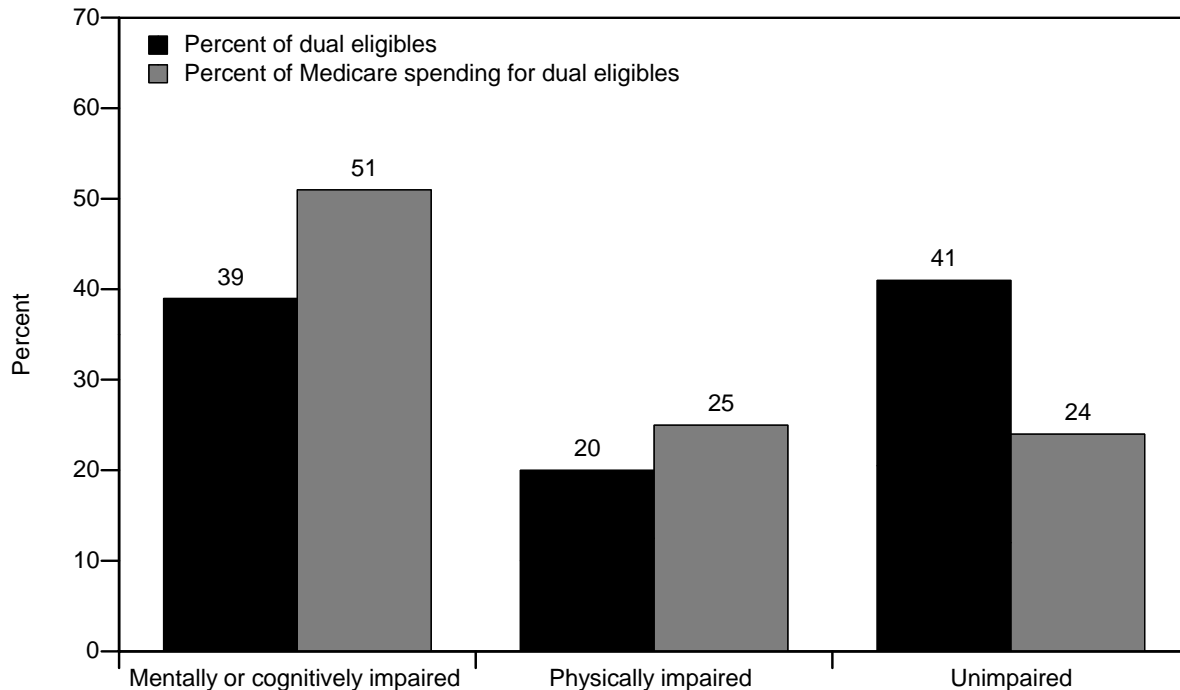


Note: Total spending includes Medicare, Medicaid, supplemental insurance, and out-of-pocket spending.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use files, 2001.

- Annual Medicare spending is concentrated among a small number of dual eligible beneficiaries. The costliest 20 percent of duals account for 80 percent of Medicare spending on duals; in contrast, the least costly 50 percent of duals account for only 3 percent of Medicare spending on duals. Of the 1 percent of all beneficiaries for whom Medicare spending is the highest, one-third are dual eligible. Similarly, of the costliest 5 percent of beneficiaries, a quarter are dual eligible.
- The distribution of total spending for dual eligibles is similar, but slightly less concentrated, than the distribution of Medicare spending. For example, the top 5 percent of duals account for 27 percent of total spending, which includes Medicare, Medicaid, supplemental insurance, and out-of-pocket spending (compared with 40 percent of Medicare spending).
- On average, total spending for duals is more than twice as high as that for nonduals—\$20,840 compared to \$10,050.

Chart 2-8. Dual eligible beneficiaries with cognitive or physical impairments account for a disproportionate share of Medicare spending, 2001



Note: Physically impaired describes beneficiaries with two or more limitations in activities of daily living (ADLs) and no mental or cognitive disabilities. Unimpaired describes dual eligible beneficiaries with fewer than two ADLs and no mental or cognitive disabilities. Mentally or cognitive impaired beneficiaries may also have physical impairment.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2001.

- Although dual eligibles as a group are costly to the Medicare program, not all dual eligibles are equally so. Overall, dual eligibles with mental, cognitive, or physical impairments are disproportionately costly for Medicare.
- On average, Medicare spends \$12,370 for each aged dual eligible with mental or cognitive problems, \$9,603 is spent for each aged dual eligible with physical impairments, and \$7,299 is spent on each disabled dual eligible with physical impairments.

Chart 2-9. Dual eligible beneficiaries report generally good access to care

Question	Percent reporting positively		
	Dual	Medicare only	Other supplemental insurance
Do you have one person you think of as your personal doctor or nurse?	84.0%	74.6%	91.0%
Did you delay seeking medical care because you were worried about the cost?	9.7	22.5	42.0
Did you usually or always get care as soon as you wanted when you needed care right away?	88.1	90.3	93.0
Did you usually or always get an appointment for regular or routine care as soon as you wanted?	86.5	90.7	92.0

Source: MedPAC analysis of the Cost and Use file and the Access to Care file, 2001 Medicare Current Beneficiary Survey, and the 2001 Consumer Assessment of Health Plans Survey.

- Dual eligible beneficiaries often possess characteristics associated with needing care—limitations in activities of daily living and poor health status, for example—as well as having difficulty obtaining care—such as being poor and poorly educated.
- Survey results indicate that most duals rate their access to care lower than beneficiaries with other sources of supplemental insurance.
- Medicare-only beneficiaries may or may not report better access to health care than dual eligibles: Duals have a slightly more difficult time getting immediate and regular care, but are more likely to have a usual source of care and less likely to delay care due to cost.

Web links. Dual eligible beneficiaries

- Chapter 3 of the MedPAC June 2004 Report to the Congress provides further information on dual eligible beneficiaries.

http://www.medpac.gov/publications/congressional_reports/June04_ch3.pdf

- The Kaiser Family Foundation provides information on dual eligible beneficiaries.

<http://kff.org>

- The CMS Medicaid Chartbook provides information on the Medicaid program.

<http://www.cms.gov/charts/medicaid/2tchartbk.pdf>

S E C T I O N

3

**Quality of care in the
Medicare program**

Chart 3-1. Effectiveness of care: Hospital mortality decreased from 1995–2002

Diagnosis or procedure	Risk-adjusted rate per 10,000 discharges				Percent change 1995–2002	Observed deaths in 2000
	1995	1998	2000	2002		
In-hospital mortality						
Pneumonia	1,122	1,032	1,012	949	–15.4	78,999
AMI	1,670	1,477	1,414	1,309	–21.6	43,750
Stroke	1,357	1,240	1,212	1,159	–14.6	39,099
CHF	689	585	541	474	–31.2	38,828
GI hemorrhage	504	434	400	355	–29.5	11,155
CABG	580	522	482	427	–26.3	8,669
Craniotomy	1,033	963	986	931	–9.9	3,216
AAA repair	1,258	1,178	1,161	1,130	–10.2	2,632
30-day mortality						
Pneumonia	1,525	1,531	1,377	1,557	2.1	107,502
CHF	1,063	1,006	818	907	–14.6	58,678
Stroke	1,816	1,808	1,620	1,807	–0.5	52,263
AMI	1,899	1,792	1,627	1,690	–11.0	50,367
GI hemorrhage	757	718	590	649	–14.3	16,438
CABG	532	496	441	412	–22.5	7,932
Craniotomy	1,164	1,158	1,123	1,182	1.6	3,666
AAA repair	1,158	1,116	1,069	1,072	–7.4	2,423

Note: AMI (acute myocardial infarction), CHF (congestive heart failure), GI (gastrointestinal), CABG (coronary artery bypass graft), AAA (abdominal aortic aneurysm). Rate is for discharge eligible to be considered in the measure.

Source: MedPAC analysis of 100 percent of MedPAR data using Agency for Healthcare Research and Quality indicators and methods.

- Rates of in-hospital mortality generally decreased between 1995 and 2002 on all conditions and procedures measured. The most substantial improvements occurred for congestive heart failure, gastrointestinal hemorrhage, and coronary artery bypass graft.
- 30-day mortality (as measured from admission) has also generally improved, though the rate of mortality following pneumonia, the most common precedent of mortality among those we measured, and craniotomy rose over the period.
- However, 30-day mortality rates (as measured from admission) decreased at a lower pace than inpatient mortality between 1995 and 2002 and actually increased between 2000 and 2002.

Chart 3-2. Effectiveness and timeliness of care in hospitals: Processes of care are improving but rates are still too low, 1998–2001

Process	1998–1999	2000–2001	
	Median state's rate	Median state's rate	Weighted average
AMI			
Aspirin in 24 hours	84%	85%	84%
Aspirin at discharge	85	86	84
Beta blockers in 24 hours	64	69	68
Beta blockers at discharge	72	79	78
Angiotensin-converting enzyme inhibitor in AMI	71	74	71
Smoking cessation counseling	40	43	38
Congestive heart failure			
Evaluation of left ventricular ejection fraction	65	70	71
Angiotensin-converting enzyme inhibitor in heart failure	69	68	66
Stroke			
Afibrillation	55	57	57
Antithrombotic	83	84	83
Nifedipine	95	99	99
Pneumonia			
Antibiotic time	85	87	85
Antibiotic prescription	79	85	84
Blood culture	82	82	81
Influenza screen	14	27	24
Pneumonia screen	11	24	23

Note: AMI (acute myocardial infarction). The rates reflect the percentage of beneficiaries receiving clinically indicated services in a state (a perfect performance is 100 percent). These data show the median state's rate for each indicator for both time periods. The weighted average is based on the number of beneficiaries in each state.

Source: CMS data from the quality improvement organization program.
Jencks S, Huff E, Cuerdon T. Change in the quality of care delivered to Medicare beneficiaries, 1998–1999 to 2000–2001, *Journal of the American Medical Association*. January 15, 2003, Vol. 289, No. 3, p. 302–312.

- Care has improved in 14 out of 16 hospital measures used by the quality improvement organization program between the periods 1998–1999 and 2000–2001. The scores for each measure that improved rose as much as 13 points.
- Because many Medicare beneficiaries are still not receiving clinically indicated services, many opportunities for further improvement exist.

Chart 3-3. Safety of care: Adverse events affect many beneficiaries, 1995–2002

Patient safety indicator	Risk-adjusted rate per 10,000 discharges eligible				Change in rate	Percent change	Observed adverse events 2000
	1995	1998	2000	2002			
Decubitus ulcer	237	273	297	319	82	34.5	128,774
Failure to rescue	1,772	1,683	1,652	1,511	–261	–14.7	57,491
Postoperative PE or DVT	98	108	120	123	25	24.5	36,795
Accidental puncture /laceration	28	31	32	36	8	30.7	34,171
Infection due to medical care	24	27	28	30	6	28.5	24,524
Latrogenic pneumothorax	10	12	11	11	1	4.8	10,985
Postoperative respiratory failure	43	66	75	87	44	99.6 ^b	8,184
Postoperative hemorrhage or hematoma	N/A	27	26	24	–3 ^a	–11.2	8,056
Postoperative Sepsis	89	112	127	135	46	50.7	6,739
Postop hip fracture	18	18	18	13	–5	–24.2	3,707
Death in low mortality DRGs	39	30	31	30	–9	–23.6 ^c	3,453
Postop wound dehiscence	38	41	37	38	0	0.4	2,043
Postoperative physiologic and metabolic derangement	11	12	13	14	3	31.8	1,952

Note: PE (pulmonary embolism), DVT (deep vein thrombosis), N/A (not available), DRGs (diagnosis-related groups).

^achange from 1998–2002

^bSome of this increase may be due to the introduction of a new code in 1998 for acute and chronic respiratory failure.

^cAgency Healthcare Research and Quality researchers identified low mortality DRGs for all-payers, not Medicare only.

Source: MedPAC analysis of 100 percent MedPAR data using Agency for Healthcare Research and Quality indicators and methods.

- From 1995 to 2002, 9 out of 13 rates of adverse events experienced by Medicare beneficiaries increased.
- Four of the indicators have seen decreasing rates; these include failure to rescue, one of the most common and, because it results in death, most severe. The other indicator related to mortality—death in low-mortality diagnosis related groups—also decreased.

Chart 3-4. Effectiveness and timeliness of care outside the hospital: The change in the rate of potentially avoidable hospital admissions is mixed, 1995–2002

Conditions	Risk-adjusted rate per 10,000 beneficiaries				Percent change 1995–2002	Observed admissions in 2000
	1995	1998	2000	2002		
Congestive heart failure	241	257	244	238	–1.0	703,012
Bacterial pneumonia	154	182	193	192	24.1	567,995
COPD	104	121	122	118	13.6	368,674
Urinary infection	60	64	67	66	9.4	209,550
Dehydration	50	55	58	65	30.2	181,785
Diabetes long-term complication	35	38	39	41	18.5	125,053
Adult asthma	24	21	20	23	–6.3	65,680
Angina without procedure	50	24	19	14	–71.4	59,983
Hypertension	9	10	11	13	38.3	37,334
Lower extremity amputation	15	16	15	14	–2.1	24,224
Diabetes short-term complication	7	7	7	7	2.1	22,425
Diabetes uncontrolled	10	8	7	6	–38.1	22,416

Note: COPD (chronic obstructive pulmonary disease).

Source: MedPAC analysis of 100 percent of MedPAR data using Agency for Healthcare Research and Quality indicators and methods.

- The top five most prevalent ambulatory care sensitive conditions in Medicare are congestive heart failure (CHF), bacterial pneumonia, chronic obstructive pulmonary disease, urinary tract infection, and dehydration.
- Rates of potentially avoidable admissions for 7 out of 12 conditions increased between 1995 and 2002. One important exception to this trend is CHF—the condition representing the most potentially avoidable admissions. Admissions for beneficiaries with CHF decreased 1 percent between 1995 and 2002.

Chart 3-5. Effectiveness and timeliness of care outside the hospital: Effective care processes are improving, but rates are still too low, 1998–2001

Process	1998–1999 Median state's rate	2000–2001	
		Median state's rate	Weighted average
Adult immunization			
Influenza	67	72	71
Pneumonia	55	65	64
Breast cancer			
Mammography	55	60	77
Diabetes			
HgbA1c	70	78	70
Eye exam	68	70	74
Lipid profile	60	74	76

Note: HgbA1c (hemoglobin A1c). The rates reflect the percentage of beneficiaries receiving clinically indicated services (a perfect performance is 100 percent). These data show the median state's rate for each indicator for both time periods. The weighted average is based on the number of beneficiaries in each state.

Source: CMS data from the quality improvement organization program.
Jencks S, Huff E, Cuerdon T. Change in the quality of care delivered to Medicare beneficiaries, 1998–1999 to 2000–2001, *Journal of the American Medical Association*. January 15, 2003, Vol. 289, No. 3, p. 302–312.

- Care has improved on all six measures of ambulatory care used by the quality improvement organization program between the 1998 to 1999 and 2000 to 2001 periods for which the measures were calculated. Scores rose as much as 16 points over this period.
- Because significant numbers of Medicare beneficiaries are still not receiving services necessary to manage a chronic condition or prevent acute episodes, many opportunities for further improvement exist.

Chart 3-6. Effectiveness and timeliness of care: Plans improve, but rates are still low on some measures, 2000–2002

Measure	2000	2001	2002
Beta-blocker treatment after heart attack	89.3%	92.9%	93.0%
Breast cancer screening	73.9	75.3	74.5
Cholesterol management			
Control	52.9	58.4	62.3
Screening	70.6	75.5	77.7
Controlling high blood pressure	46.7	53.6	56.9
Comprehensive diabetes care			
Eye exams	62.8	66.0	68.4
HbA1c control	82.5	85.7	85.0
Lipid control	50.9	57.5	62.6
Lipid profile	80.5	85.7	87.9
Monitoring diabetic nephropathy	45.0	51.9	57.3
Poor HbA1c control*	33.4*	26.8*	24.5*
Antidepressant medication management**			
Acute phase	N/A	51.3	52.1
Continuation phase	N/A	36.8	37.7
Contacts	N/A	11.9	10.8
Follow-up after hospitalization for mental illness			
Less than 7 days	37.5	37.2	38.7
Less than 30 days	59.3	60.6	60.6

Note: HbA1c (hemoglobin A1c). N/A (not available). Rates refer to patients for whom the treatments were clinically indicated treatment.

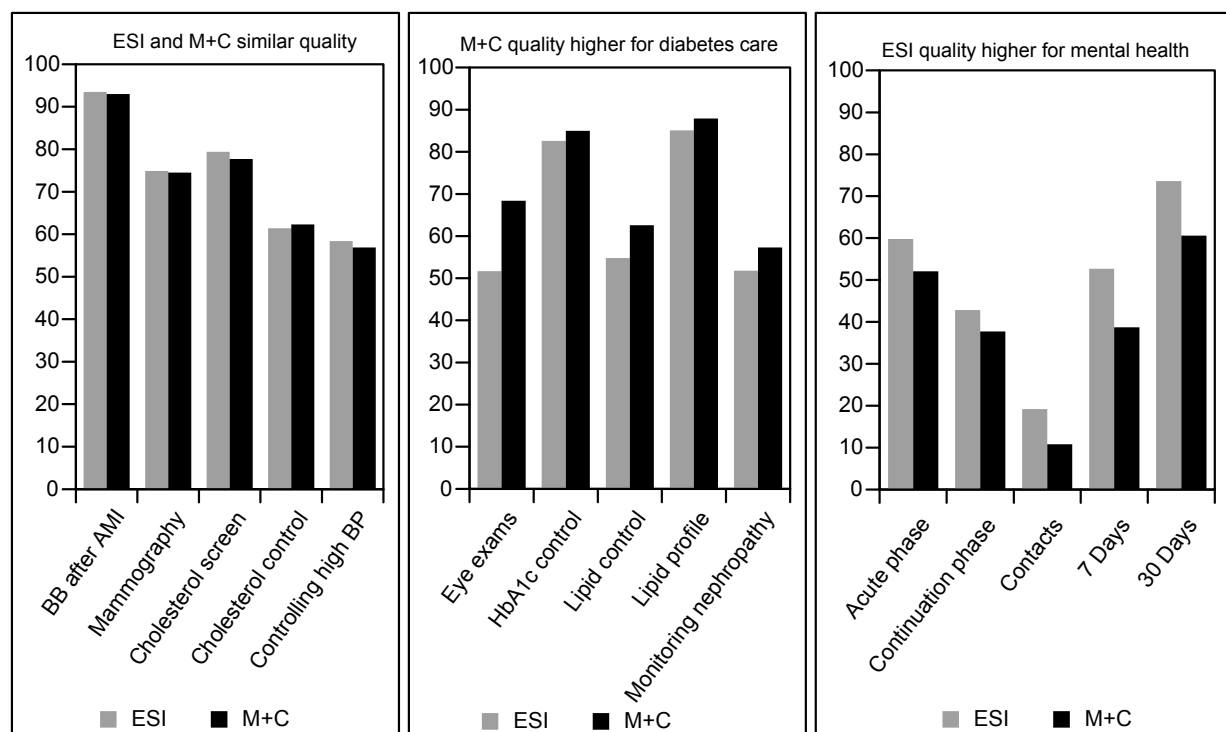
* Lower rates are better than higher ones for this measure.

** Acute phase refers to the percent of patients receiving effective treatment after a new episode. Continuation refers to the percent of patients remaining on antidepressant continuously for six months after initial diagnosis. Contacts refers to the percent of patients who received at least 3 follow-up office visits in a 12-week acute phase.

Source: National Committee For Quality Assurance 2003, or The State of Health Care Quality. Washington, DC: NCQA.

- Care on almost all of the 16 measures reported for Medicare+Choice (M+C)—now Medicare Advantage—plans improved over the last 3 years. Rates of provision of two services decreased.
- Because many Medicare beneficiaries in M+C are still not receiving clinically indicated services, many opportunities for further improvement exist.

Chart 3-7. Effectiveness and timeliness of care: M+C and employer-sponsored plans' performances have similarities and differences, 2002



Note: ESI (employer-sponsored insurance), M+C (Medicare+Choice), BB (beta blocker), AMI (acute myocardial infarction), BP (blood pressure), HbA1c (hemoglobin A1c).

Source: Health Plan Employer Data and Information Set data, 2002, from National Committee for Quality Assurance.

- Medicare+Choice (M+C)—now Medicare Advantage—plan scores are comparable to those for plans serving employer-sponsored members on most Health Plan Employer Data and Information Set measures.
- However, M+C plans score higher on measures of good diabetes care. This difference might reflect the emphasis CMS places on the treatment of diabetics in the Medicare program. CMS identified care for diabetics as the first national quality project for its managed care plans in 1999 and has also made it a focus of the quality improvement organization program.
- On measures of the quality of care provided to the mentally ill, however, Medicare managed care plans score lower than their employer-sponsored counterparts. Fewer Medicare beneficiaries receive appropriate follow-up after hospitalization for mental illness and effective management after an acute episode or on an ongoing basis.

Chart 3-8. Patient-centeredness of care: Continuity and access to providers is stable

Question	2000	2001	2002
Do you have one person you think of as your personal doctor or nurse (the health provider who knows you best)?			
Yes	N/A	89.0%	89.0%
No	N/A	11.0	11.0
How many months or years have you been going to your personal doctor or nurse?			
2 years or more	N/A	79.2	78.9
Less than 2 years	N/A	20.8	21.1
In the last 6 months, how much of a problem, if any, was it to see a specialist that you needed to see?			
None or small problem	93.6	94.8	94.3*
Big problem	6.4	5.2	5.7*

Note: N/A (not available).

*Indicates a statistically significant change between 2000 and 2002, at a 95% confidence level ($p < 0.05$).

Source: MedPAC analysis of CAHPS (Consumer Assessment of Health Plans Survey) for fee-for-service Medicare, 2000–2002.

- Beneficiaries' access to personal doctors or nurses appears to be consistently good, and almost 80 percent of beneficiaries report that they have been going to their personal doctors or nurses for two or more years.
- In 2002, about 50 percent of beneficiaries reported that they needed to see specialists; of those beneficiaries, 94 percent said that it was a small or no problem to see the specialists. Only 6 percent said that it was a big problem.

Chart 3-9. Patient-centeredness of care: Beneficiaries rate interactions with health care providers highly

Question	2000	2001	2002
Care			
How would you rate your personal doctor or nurse?	84.7%	83.5%	83.7%*
How would you rate the specialist you saw most often in the last 6 months, including a personal doctor if he or she is a specialist?	85.5	83.3	84.4*
How would you rate all the health care you got in the last 6 months from all doctors and other health providers?	85.4	84.8	85.2
Quality of interactions			
In the last 6 months, how often did doctors or other health providers:			
Usually or always listen carefully to you?	94.8	94.8	94.6
Usually or always explains things in a way you could understand?	93.4	93.7	93.8*
Usually or always show respect for what you had to say?	94.9	94.7	94.8
Usually or always spend enough time with you?	91.1	90.9	90.6*

Note: *Indicates a statistically significant change between 2000 and 2002, at a 95% confidence level ($p < 0.05$). Percentages may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Consumer Assessment of Health Plans Survey (CAHPS) for fee-for-service Medicare, 2000–2002.

- More than 80 percent of beneficiaries gave a rating of 8 or higher on a scale of 1 to 10 (10 being the highest) to their personal doctor or nurse and the specialist that they saw most often in the last 6 months. The same was true for all the health care they received in the last 6 months.
- They also highly rate the quality of interactions with their doctor or other health provider. For example, between 93 and 95 percent of beneficiaries reported that their doctors or other health care providers usually or always listened carefully to them, explained things in a way that they could understand, and showed respect for what they had to say.
- Beneficiaries are slightly less satisfied with the amount of time spent with their personal doctor or nurse; but still, over 90 percent are satisfied with this aspect of their health care.

Chart 3-10. Patient-centeredness of care: Medicare rates higher than employer-sponsored plans in 2001

Measure	FFS	M+C	Employer-sponsored
No problem getting care when needed	89%	82%	77%
Usually or always got care without long waits	87	87	79
Doctors in health plan usually or always communicate well	94	93	91
Rated health care overall 8-10	84	84	73
Rated health plan 8-10	78	77	62

Note: FFS (fee-for-service), M+C (Medicare+Choice). The ratings on the last two indicators show the percentage of beneficiaries who gave ratings of 8 or higher on a scale of 1 to 10.

Source: MedPAC analysis of 2001 Consumer Assessment of Health Plans Survey (CAHPS) data for fee-for-service and Medicare+Choice plans from CMS; and 2001 CAHPS data on employer-sponsored plans from the National Committee for Quality Assurance.

- Beneficiaries' ratings of satisfaction with FFS and M+C are generally similar.
- Beneficiaries report obtaining care when they need it and do not report long waits.
- Some 84 percent of beneficiaries in both programs give their health care high ratings.

Web links. Quality of care in the Medicare program

- Chapter 2 of the MedPAC March 2004 Report to the Congress includes and discusses in further detail many of these charts.

http://www.medpac.gov/publications/congressional_reports/Mar04_Ch2.pdf

- Chapter 7 of the MedPAC June 2003 Report to the Congress provides further information on quality measurement issues in various settings and how to use incentives, including linking payment to performance, to improve quality.

http://www.medpac.gov/publications/congressional_reports/June03_Ch7.pdf

- Chapter 3 of the MedPAC June 2003 Report to the Congress provides further information on dialysis quality.

http://www.medpac.gov/publications/congressional_reports/June03_Ch3.pdf

- The CMS website provides further information on CMS quality initiatives.

<http://www.cms.hhs.gov/quality>

- Chapters 3E and 4 of the MedPAC March 2004 Report to the Congress discuss our recommendations to link payment to quality for dialysis facilities and physicians and Medicare Advantage plans.

http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3E.pdf

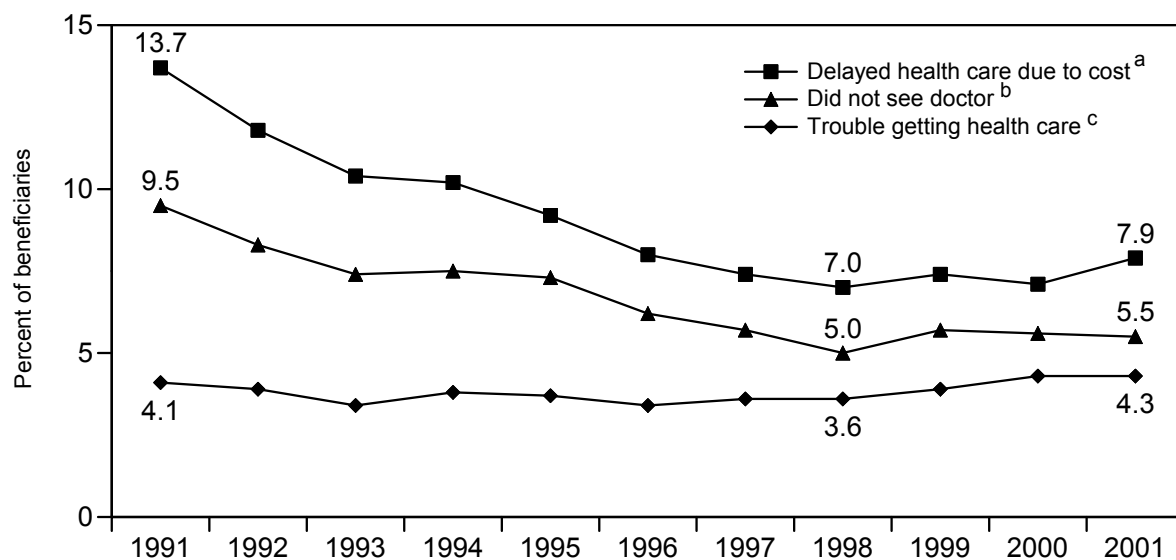
http://www.medpac.gov/publications/congressional_reports/Mar04_Ch4.pdf

S E C T I O N

4

Access to care in the Medicare program

Chart 4-1. Beneficiaries' reports of difficulties obtaining care have declined or remained stable since 1991



Note: These data reflect the answers given by noninstitutionalized beneficiaries.

^a Answered "yes" when asked if they delayed seeking medical care because they were worried about the cost.

^b Answered "yes" when asked if they had a serious health problem or condition about which they should have seen a doctor or other medical person, but did not.

^c Answered "yes" when asked if they had any trouble getting health care that they wanted or needed.

Source: CMS analysis of Medicare Current Beneficiary Survey, Access to Care file.

- Since 1991, the number of beneficiaries reporting problems has declined or remained stable.
- In 2001 more than 90 percent of beneficiaries reported good access to care, regardless of the question asked.
- When asked whether they delayed health care due to cost, 14 percent of beneficiaries answered yes in 1991, compared to 8 percent in 2001.
- Similarly, the percentage reporting that they did not see a doctor (when they needed to) declined from 9.5 percent in 1991 to 5.5 percent in 2001.
- The percentage of beneficiaries who reported trouble getting health care has remained relatively stable at around 4 percent.

Chart 4-2. Access continues to be generally good, 2000–2002

Access to care	2000	2001	2002
Small or no problem getting necessary care	97%	98%	97%
Usually or always get urgent care as soon as wanted	93	92	92
Usually or always get routine appointments as soon as wanted	93	92	90

Source: MedPAC analysis of 2000–2002 Consumer Assessment of Health Plans Survey (CAHPS) data from CMS.

- In 2000, 2001, and 2002 at least 97 percent of beneficiaries who required care reported no problem or a small problem receiving necessary care.
- In 2002, 92 percent of beneficiaries who needed urgent care also reported that they were always or usually able to receive it as soon as they wanted and 90 percent said the same about routine appointments.
- However, while access to urgent care and routine appointments was high, it declined slightly from 2000 to 2002.

Chart 4-3. Continuity and access to providers is stable, 2000–2002

Question	2000	2001	2002
Do you have one person you think of as your personal doctor or nurse (the health provider who knows you best)?			
Yes	N/A	89.0%	89.0%
No	N/A	11.0	11.0
How many months or years have you been going to your personal doctor or nurse?			
2 years or more	N/A	79.2	78.9
Less than 2 years	N/A	20.8	21.1
In the last 6 months, how much of a problem, if any, was it to see a specialist who you needed to see?			
None or small problem	93.6	94.8	94.3*
Big problem	6.4	5.2	5.7*

Note: N/A (not available).

*Indicates a statistically significant change between 2000 and 2002, at a 95% confidence level ($p < 0.05$).

Source: MedPAC analysis of CAHPS (Consumer Assessment of Health Plans Survey) for fee-for-service Medicare, 2000–2002.

- Beneficiaries' access to personal doctors or nurses appears to be consistently good, and almost 80 percent of beneficiaries report that they have been going to their personal doctors or nurses for two or more years.
- In 2002, about 50 percent of beneficiaries reported that they needed to see specialists; of those beneficiaries, 94 percent said that it was a small or no problem to see the specialists. Only 5 percent said that it was a big problem.

Chart 4-4. Beneficiaries differ in their reports of obtaining needed, urgent, or routine care, 2001

Beneficiary characteristic	No problem getting needed care	Always got care as soon as wanted	
		Urgent	Routine
Overall	90%	73%	67%
Aged	91	75	67
Disabled	84	66	62
White	92	74	68
African American	86	70	67
Hispanic	84	64	59
Medicare only	87	68	66
Dually eligible	82	68	62
Additional with Rx	93	75	67
Additional without Rx	92	75	67

Source: MedPAC analysis of data from the Medicare Fee-for-Service National Implementation Subgroup Analysis: Final Report for Year 2, March 2003, submitted to CMS by the Research Triangle Institute.

- The percentage of beneficiaries reporting no problem getting needed care is significantly higher than those who reported that they can get urgent or routine care as soon as they wanted it. This may seem inconsistent, but the last two questions add the dimension of timing into their responses. It appears that while most beneficiaries are able to get care, they may not be getting it as soon as they want it.
- Disabled beneficiaries were more likely than aged beneficiaries to report problems receiving necessary, urgent, or routine care.
- The presence and type of supplemental insurance also affected beneficiaries' ability to obtain care with no problems. Sixty-eight percent of dually eligible beneficiaries reported they always got urgent care as soon as they wanted, compared with 73 percent of all beneficiaries. Those without any supplemental insurance reported the same experience. Hispanics had a harder time than other ethnic or racial groups getting needed, urgent, and routine care.

Chart 4-5. Physicians' acceptance of all or some new Medicare patients is high, but has decreased some between 1999 and 2002

Type of insurance	1999	2002	Percentage point change
Private FFS and PPO			
All or some new patients	97.9%	99.3%	1.4*
All	76.3	76.4	
Some	21.7	22.8	
FFS Medicare			
All or some new patients	96.8	95.9	-0.9
All	76.4	70.1	
Some	20.4	25.9	
HMO and other capitated plan			
All or some new patients	87.6	86.3	-1.3
All	56.4	49.6	
Some	31.2	36.7	
Medicaid			
All or some new patients	73.7	69.5	-4.2*
All	48.1	39.4	
Some	25.6	30.2	
Other (uninsured, self-pay, charity)			
All or some new patients	90.5	92.8	2.3
All	52.3	47.9	
Some	38.2	44.9	

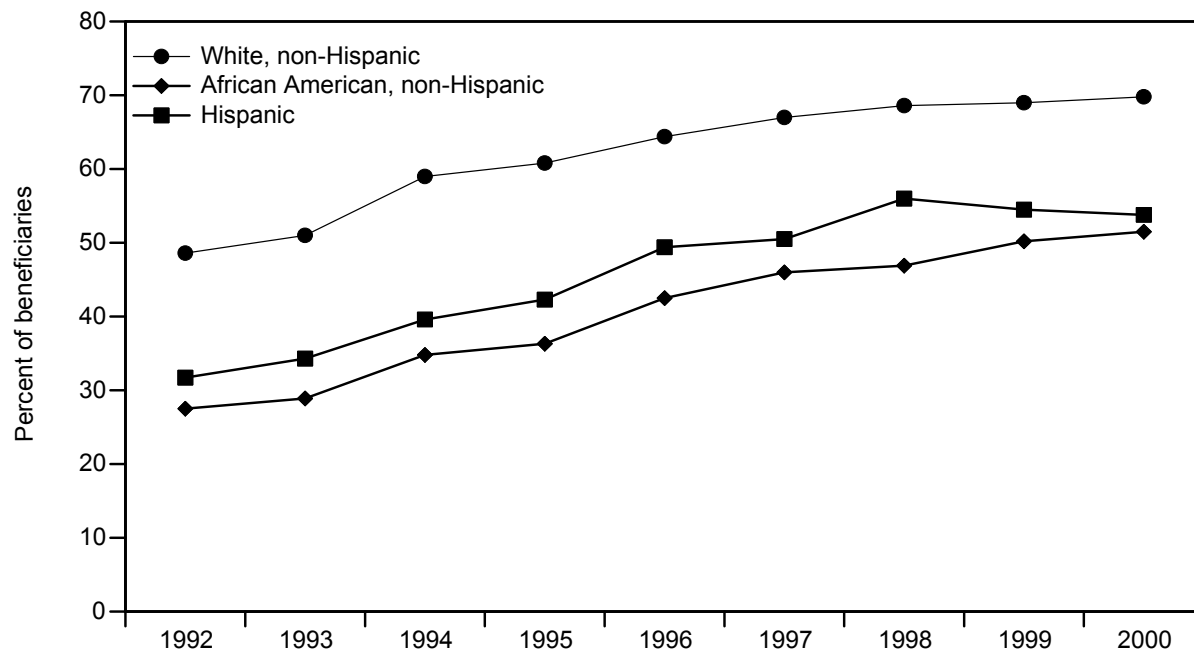
Note: FFS (fee-for-service), PPO (preferred provider organization), HMO (health maintenance organization). HMO includes Medicare HMO. Comparisons over time by type of insurance may not be valid due to changes in classification of the insurance. Analysis limited to physicians who were accepting new patients (regardless of type) in the survey year. Totals may not sum to 100 due to rounding.

*Change since 1999 statistically significant at the 95 percent confidence level.

Source: MedPAC survey of physicians, 1999 and 2002.

- Nearly all (96 percent) physicians accepted all or some new Medicare fee-for-service (FFS) patients in both 1999 and 2002.
- There was little change in the proportion of physicians accepting all or some new Medicare FFS patients between 1999 and 2002. However, physicians were more likely to accept private patients and less likely to accept Medicaid patients during this time. While this was true in 1999, the difference is more pronounced in 2002.
- The percentage of physicians accepting all new Medicare FFS patients dropped from 76 to 70 percent from 1999 to 2002. The percentage of physicians accepting only some new Medicare fee-for-service patients rose from 20 to 26 percent from 1999 to 2002.
- More information about beneficiary access to physicians can be found in Section 5 of the MedPAC 2002 Survey of Physicians About the Medicare Program, available at http://www.medpac.gov/publications/contractor_reports/Mar03_02PhysSurv_summary2.pdf.

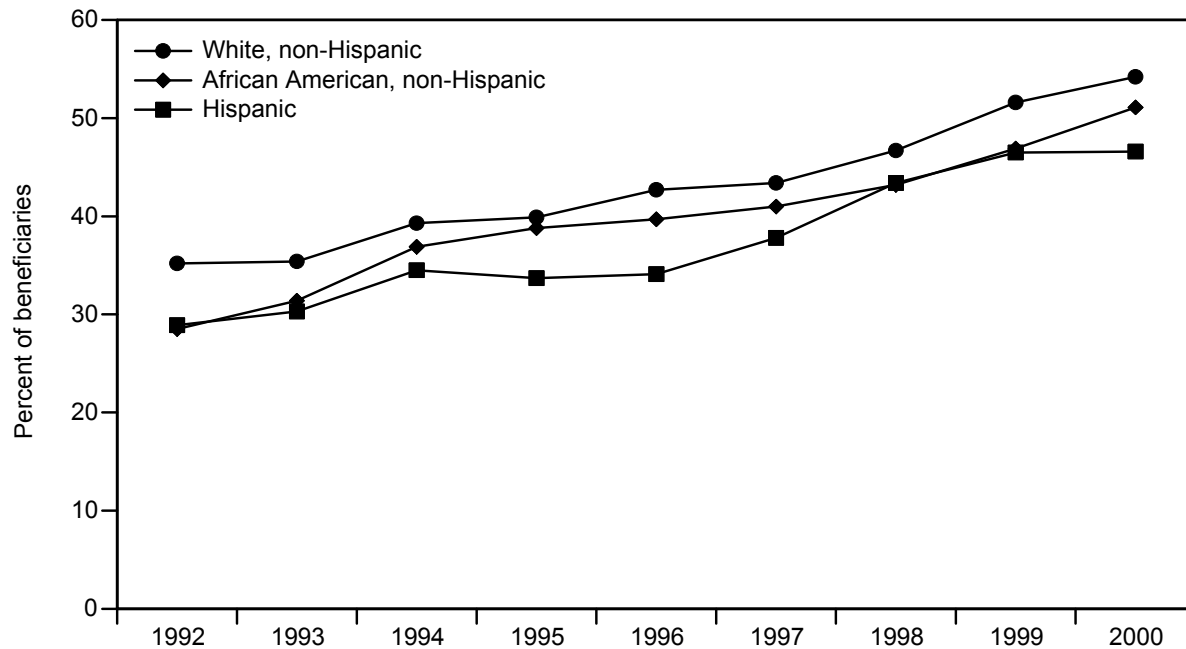
Chart 4-6. Number of beneficiaries receiving influenza shots increases, but varies by race, 1992–2000



Source: CMS, Office of Research, Development, and Information, Chart series, 2002.

- Use of influenza shots for all groups increased over the decade but use was higher for white non-Hispanic beneficiaries than for other racial groups.
- The overall use of influenza shots among Medicare beneficiaries in 2000 was 68 percent. The Centers for Disease Control and Prevention recommends that all older persons receive an influenza shot annually.
- Influenza is associated with significant morbidity and increased mortality among the elderly.

Chart 4-7. Number of female beneficiaries receiving mammograms increasing, but varies by race, 1992–2000



Source: CMS, Office of Research, Development, and Information, Chart series, 2002.

- The rates of mammogram use for all groups have increased over the decade. However, white non-Hispanic beneficiaries use these services more than other racial groups.
- Routine screening for breast cancer every 1 to 2 years, with mammography alone or mammography and annual clinical breast examination, is recommended for all women ages 40 and older.
- Medicare has provided screening mammography since January 1, 1991 (1834(c) of the Social Security Act, as added by 4163(b)(2) of the Omnibus Budget Reconciliation Act of 1990, P.L. 101–508).

Web links. Access to care in the Medicare program

- Chapter 3 of the MedPAC March 2003 Report to the Congress provides a broad overview about beneficiary access to health care.

http://www.medpac.gov/publications/congressional_reports/Mar03_Ch3.pdf

- One section in Chapter 1 of the MedPAC March 2004 to the Congress provides more information on beneficiary perception of access to health care from the fee-for-service Consumer Assessment of Health Plan Survey and the Medicare Current Beneficiary Survey.

http://www.medpac.gov/publications/congressional_reports/Mar04_Ch1.pdf

- Section 5 of the MedPAC 2002 Survey of Physicians About the Medicare Program provides more information about beneficiary access to physicians.

http://www.medpac.gov/publications/contractor_reports/Mar03_02PhysSurv_summary2.pdf

- The CMS Chart series provides information on the Medicare program, including beneficiary access to care.

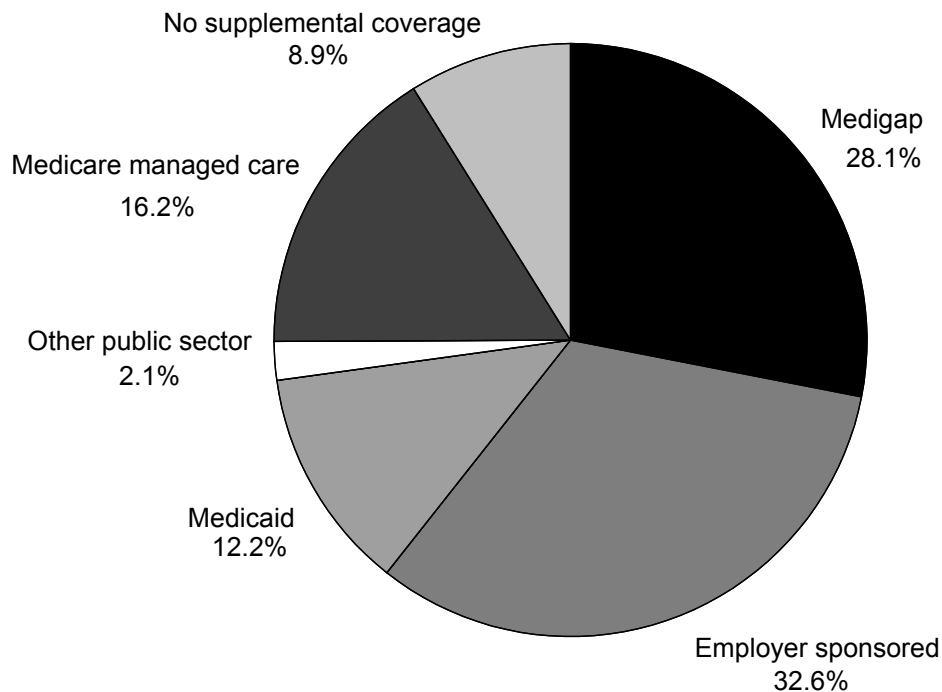
<http://www.cms.gov/charts>

S E C T I O N

5

Medicare beneficiary and other payer financial liability

Chart 5-1. Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, 2001



Note: Beneficiaries are assigned to the supplemental coverage category that applied for the most time in 2001. They could have had coverage in other categories throughout 2001. Other public sector includes federal and state programs not included in other categories. Analysis includes only beneficiaries living in the community.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2001.

- Most beneficiaries living in the community have coverage that supplements or replaces the Medicare benefit package. Ninety-one percent of beneficiaries have supplemental coverage or participate in Medicare managed care.
- Sixty-one percent have private-sector supplemental coverage such as Medigap (28 percent) or employer-sponsored retiree coverage (33 percent).
- Fourteen percent have public-sector supplemental coverage, primarily Medicaid.
- Sixteen percent participate in Medicare managed care. This includes Medicare+Choice (now Medicare Advantage), cost, and health care prepayment plans. These types of arrangements generally replace Medicare coverage and often add to it.

Chart 5-2. Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, by beneficiaries' characteristics, 2001

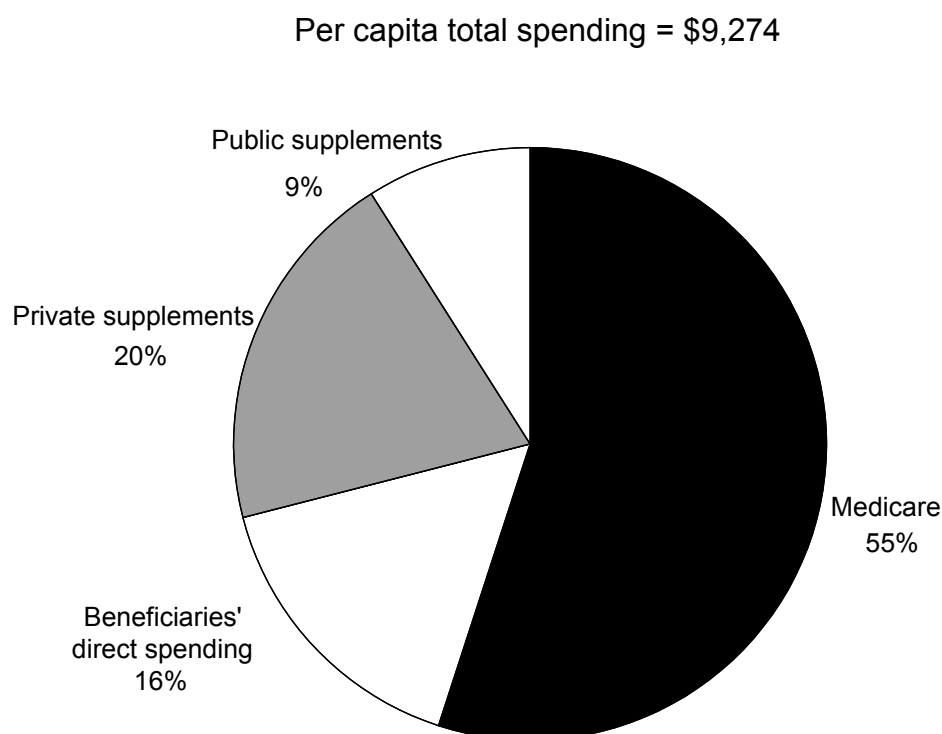
	Number of beneficiaries	Employer-sponsored insurance	Medigap insurance	Medicaid	Medicare managed care	Other public sector	Medicare only
All beneficiaries	38,508	32.6%	28.1%	12.2%	16.2%	2.1%	8.9%
Demographics							
Male	17,148	35.0	24.8	10.5	15.5	2.3	12.0
Female	21,360	30.8	30.8	13.5	16.7	1.9	6.4
< 65	5,304	27.9	5.8	35.2	8.2	3.9	19.0
65–69	9,228	38.8	24.2	8.6	17.3	1.7	9.5
70–74	8,439	32.7	32.0	7.5	18.3	2.0	7.4
75–79	7,182	32.6	34.8	8.8	16.8	1.5	5.6
80–84	4,808	30.7	36.2	8.4	17.8	1.7	5.2
85+	3,547	26.5	38.1	9.9	16.4	2.0	7.2
Income status							
Below poverty	5,911	9.3	15.2	51.7	10.7	2.3	10.8
100–125% of poverty	3,966	19.2	23.1	22.7	15.4	2.7	16.8
125–200% of poverty	7,773	29.0	31.1	6.6	18.8	2.8	11.6
200–400% of poverty	11,570	40.4	30.1	1.2	19.2	1.5	7.5
Over 400% of poverty	9,175	46.9	33.8	0.3	13.8	1.7	3.5
Eligibility status							
Aged	33,086	33.4	31.7	8.4	17.4	1.8	7.3
Disabled	5,111	27.2	5.8	35.1	8.5	4.0	19.4
ESRD	311	39.1	10.7	37.2	6.3	1.0	5.8
Residence							
Urban	29,315	34.3	24.4	11.6	20.3	1.9	7.5
Rural	9,168	27.1	40.1	14.0	3.0	2.6	13.3
Health status							
Excellent/very good	15,591	35.3	32.1	5.7	17.9	1.5	7.4
Good/fair	19,235	31.4	26.8	14.6	15.7	2.3	9.1
Poor	3,521	28.0	17.0	27.5	10.6	3.5	13.4

Note: ESRD (end-stage renal disease). Beneficiaries are assigned to the supplemental coverage that applied for the most time in 2001. They could have had coverage in other categories throughout 2001. Medicare managed care includes Medicare+Choice (now Medicare Advantage), cost, and health care prepayment plans. Other public sector includes federal and state programs not included in other categories. In 2001, poverty was defined as \$8,494 for people living alone and as \$10,715 for married couples. Urban indicates beneficiaries living in metropolitan statistical areas (MSAs). Rural indicates beneficiaries living outside MSAs. Analysis includes only beneficiaries living in the community.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2001.

- Employer-sponsored supplemental coverage is most common among those who are age 65 to 79, high income (above 200 percent of poverty), eligible due to age or ESRD, urban dwelling, and male, and who report excellent or very good health.
- Medigap is most common among those who are “old” aged (age 80 or older), middle or high income (above 125 percent of poverty), eligible due to age, rural dwelling, female, and who report excellent or very good health.
- Medicaid coverage is most common among those who are under 65, low income (below 125 percent of poverty), eligible due to disability or ESRD, rural dwelling, and female, and who report poor health.
- Medicare managed care is most common among those who are age 65 or older, middle income (between 125 and 400 percent of poverty), eligible due to age, urban dwelling, female, and who report excellent or very good health.
- Lack of supplemental coverage (Medicare coverage only) is most common among beneficiaries who are under age 65, with income between 100 and 125 percent of poverty, eligible due to disability, rural dwelling, male, and who report poor health.

Chart 5-3. Total spending on health care services for noninstitutionalized FFS Medicare beneficiaries, by source of payment, 2001

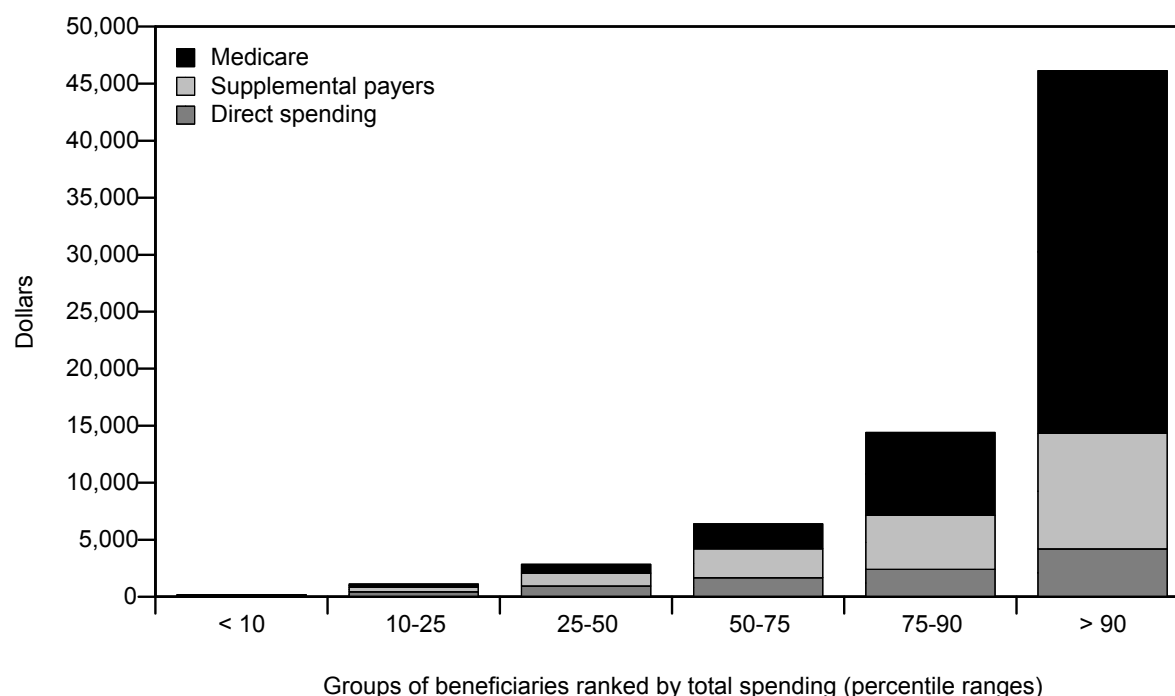


Note: FFS (fee-for-service). Private supplements include employer-sponsored plans and individually-purchased coverage. Public supplements include Medicaid, Department of Veterans Affairs, and other public coverage. Direct spending is on Medicare cost sharing and noncovered services but not supplemental premiums. Analysis includes only FFS beneficiaries living in the community.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2001.

- Among fee-for-service (FFS) beneficiaries living in the community, the total cost of health care services (defined as beneficiaries' out-of-pocket spending as well as expenditures by Medicare, other public-sector sources, and all private-sector sources on all health care goods and services) averages \$9,274. Medicare is the largest source of payment; it pays 55 percent of the health care costs for FFS beneficiaries living in the community, or an average of \$5,058 per beneficiary.
- Private sources of supplemental coverage—primarily employer-sponsored retiree coverage and Medigap—pay 20 percent of beneficiaries' costs, or an average of \$1,837 per beneficiary.
- Beneficiaries pay 16 percent of their health care costs out of pocket, with an average of \$1,503 of spending per beneficiary.
- Public sources of supplemental coverage—primarily Medicaid—pay 9 percent of beneficiaries' health care costs, or an average of \$876 per beneficiary.

Chart 5-4. Per capita total spending on health care services among noninstitutionalized FFS beneficiaries, by source of payment, 2001

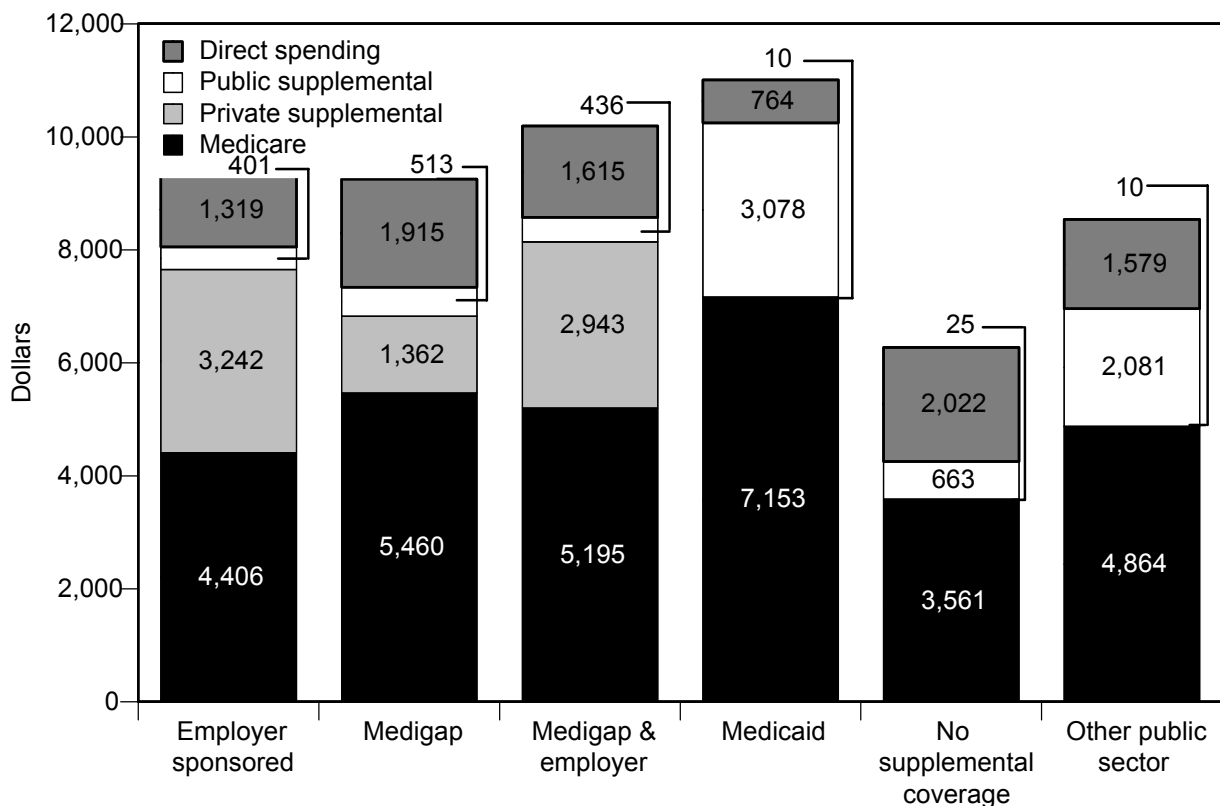


Note: FFS (fee-for-service). Analysis includes only FFS beneficiaries living in the community in 2001. Direct spending is on Medicare cost sharing and noncovered services but not supplemental premiums. Totals may not sum to 100 due to rounding.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2001.

- Total spending on health care services varies dramatically across fee-for-service (FFS) beneficiaries living in the community. Spending for the 10 percent of beneficiaries with the highest total spending averages \$46,100. Spending for the 10 percent of beneficiaries with the lowest total spending averages \$170.
- Among FFS beneficiaries living in the community, Medicare pays a larger percentage as total spending increases, and beneficiaries' direct spending is a smaller percentage as total spending increases. For example, Medicare pays 55 percent of total spending for all beneficiaries, but 69 percent of total spending for the 10 percent of beneficiaries with the highest total spending. Beneficiaries' direct spending covers 16 percent of total spending for all beneficiaries, but only 9 percent of total spending for the 10 percent of beneficiaries with highest total spending.

Chart 5-5. Variation in and composition of total spending among noninstitutionalized FFS beneficiaries, by type of supplemental coverage, 2001

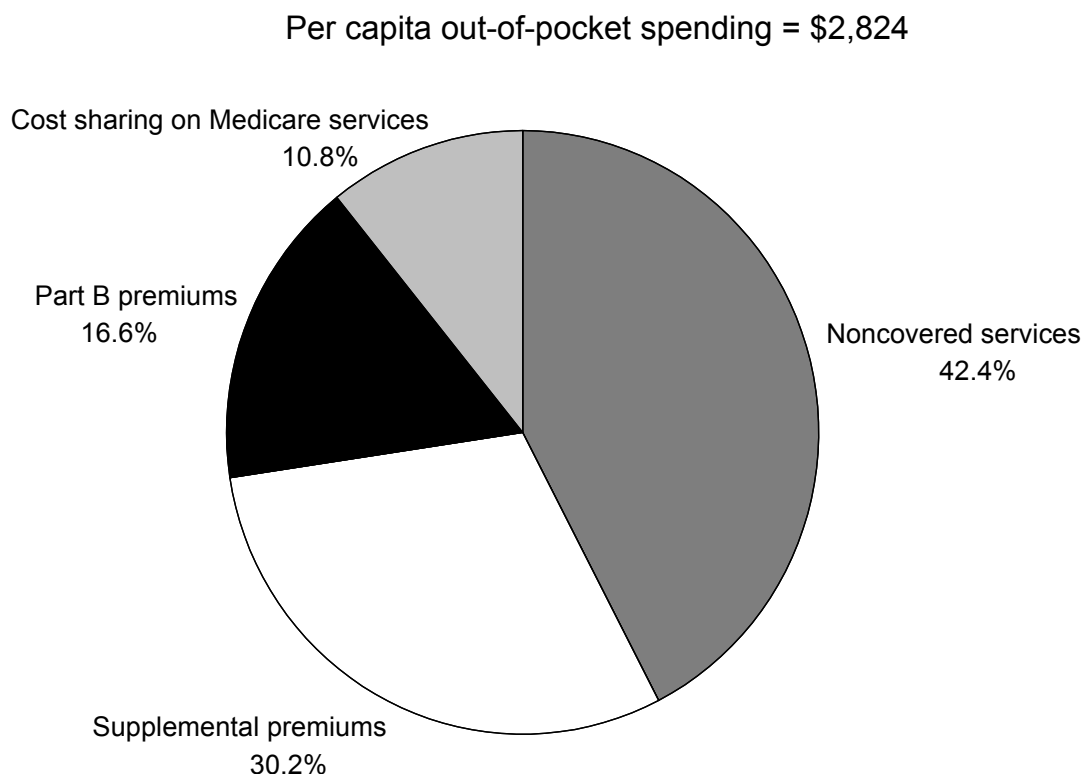


Note: FFS (fee-for-service). Beneficiaries are assigned to the supplemental coverage category that applied for the most time in 2001. They could have had coverage in other categories throughout 2001. Other public sector includes federal and state programs not included in the other categories. Private supplements include employer-sponsored plans and individually-purchased coverage. Public supplements include Medicaid, Department of Veterans Affairs, and other public coverage. Analysis includes only FFS beneficiaries living in the community. Direct spending is on Medicare cost sharing and noncovered services but not supplemental premiums.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2001.

- The level of total spending (defined as beneficiaries' out-of-pocket spending as well as expenditures by Medicare, other public-sector sources, and all private-sector sources on all health care goods and services) among fee-for-service beneficiaries living in the community varies by the type of supplemental coverage they have. Total spending is much lower for those beneficiaries with no supplemental coverage than for those beneficiaries who have supplemental coverage. Beneficiaries with Medicaid coverage have the highest level of total spending, nearly twice as high as for those with no supplemental coverage.
- Medicare is the largest source of payment for beneficiaries in each supplemental insurance category, but the second largest source of payment differs. Among those with employer-sponsored or public supplemental coverage (Medicaid and other public), supplemental coverage is the second largest source of payment. However, among those with Medigap (and no employer-sponsored coverage) and those with Medicare only, beneficiaries' direct spending is the second largest source of payment.

Chart 5-6. Types of out-of-pocket spending among noninstitutionalized FFS beneficiaries, 2001

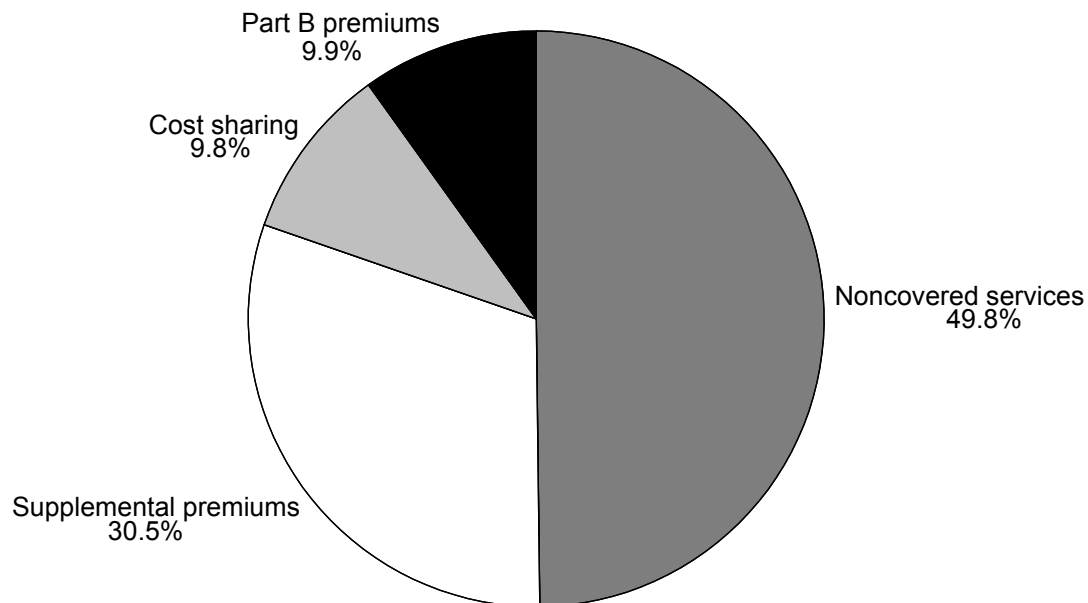


Note: FFS (fee-for-service). Analysis includes only FFS beneficiaries living in the community. Totals may not sum to 100 due to rounding.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2001.

- Many beneficiaries have substantial health care liabilities that Medicare does not cover. Medicare has cost sharing on services it covers, and in the year represented by the data (2001), Medicare did not cover services such as most outpatient prescription drugs and dental care. Beginning in 2006, Medicare will have a voluntary prescription drug program.
- The cost sharing and noncovered services must be paid out of pocket by beneficiaries or through supplemental coverage. Beneficiaries often pay out of pocket for some or all premiums for supplemental coverage. Moreover, they generally pay out of pocket for the Part B premium.
- Average per capita out-of-pocket spending in 2001 was \$2,824 for fee-for-service beneficiaries living in the community. Noncovered services made up the largest share—42 percent—of that amount in 2001. The share of out-of-pocket spending attributable to noncovered services will likely decline in 2006, when the voluntary drug program begins.

Chart 5-7. Sources of change in out-of-pocket spending among noninstitutionalized FFS beneficiaries, 1993–2001

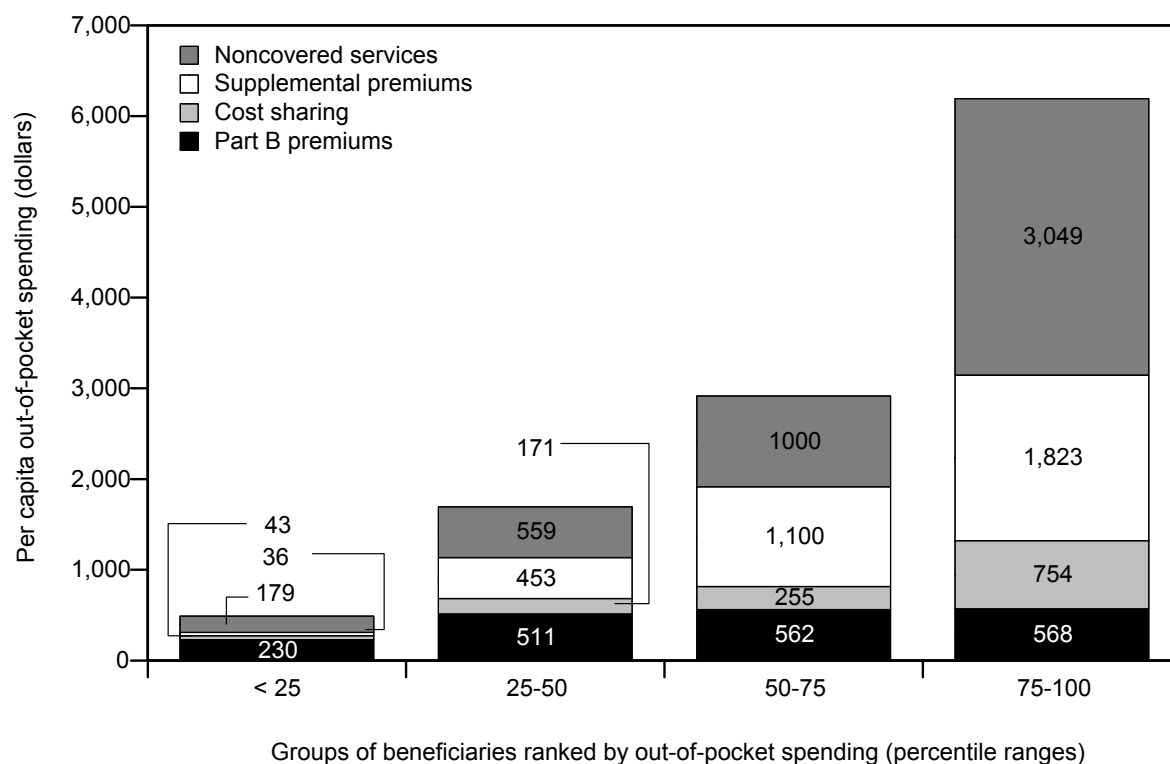


Note: FFS (fee-for-service). Analysis includes only FFS beneficiaries living in the community. Analysis does not adjust for inflation.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2001

- Some components of out-of-pocket spending have contributed much more than others to overall increases in out-of-pocket spending. Among fee-for-service beneficiaries living in the community, per capita out-of-pocket spending increased from \$1,784 in 1993 to \$2,824 in 2001, about 5.9 percent annually. Noncovered services, such as outpatient prescription drugs, account for the largest share—50 percent—of the increase.

Chart 5-8. Out-of-pocket spending among noninstitutionalized FFS beneficiaries, by out-of-pocket spending level, 2001

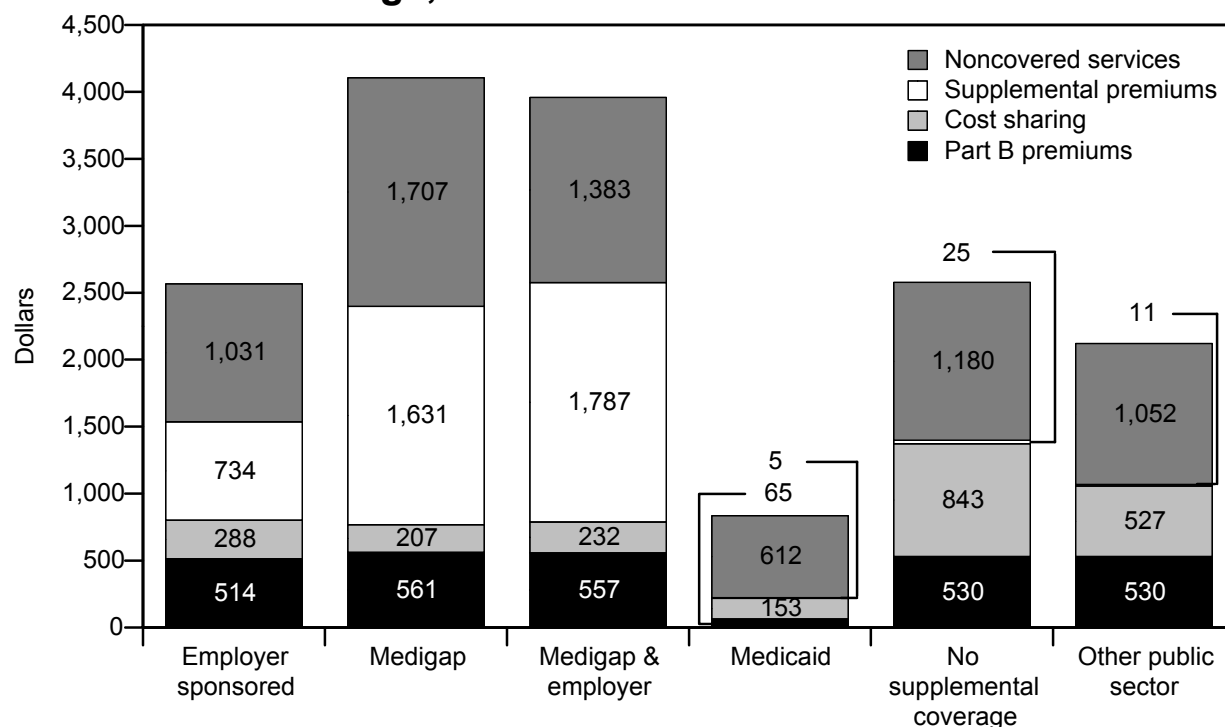


Note: FFS (fee-for-service). Sample of 9,703 includes only community-dwelling, FFS beneficiaries in 2001.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2001.

- The level of out-of-pocket spending varies widely among fee-for-service beneficiaries living in the community. The 25 percent of beneficiaries with the lowest out-of-pocket spending average \$500. The 25 percent of beneficiaries with the highest out-of-pocket spending average \$6,200.
- The composition of out-of-pocket spending changes as spending increases. Noncovered services and supplemental premiums tend to represent a larger share as out-of-pocket spending increases. Relative to the other categories, cost sharing maintains a more constant share as out-of-pocket spending increases. Finally, the Part B premium tends to represent a decreasing share as out-of-pocket spending increases, even though the magnitude of out-of-pocket spending on the Part B premium tends to increase. The relatively low level of out-of-pocket spending on the Part B premium in the lowest quartile (\$230) reflects, in part, the fact that beneficiaries eligible for Medicaid do not pay out of pocket for the Part B premium.

Chart 5-9. Out-of-pocket spending among noninstitutionalized FFS beneficiaries, by type of supplemental coverage, 2001

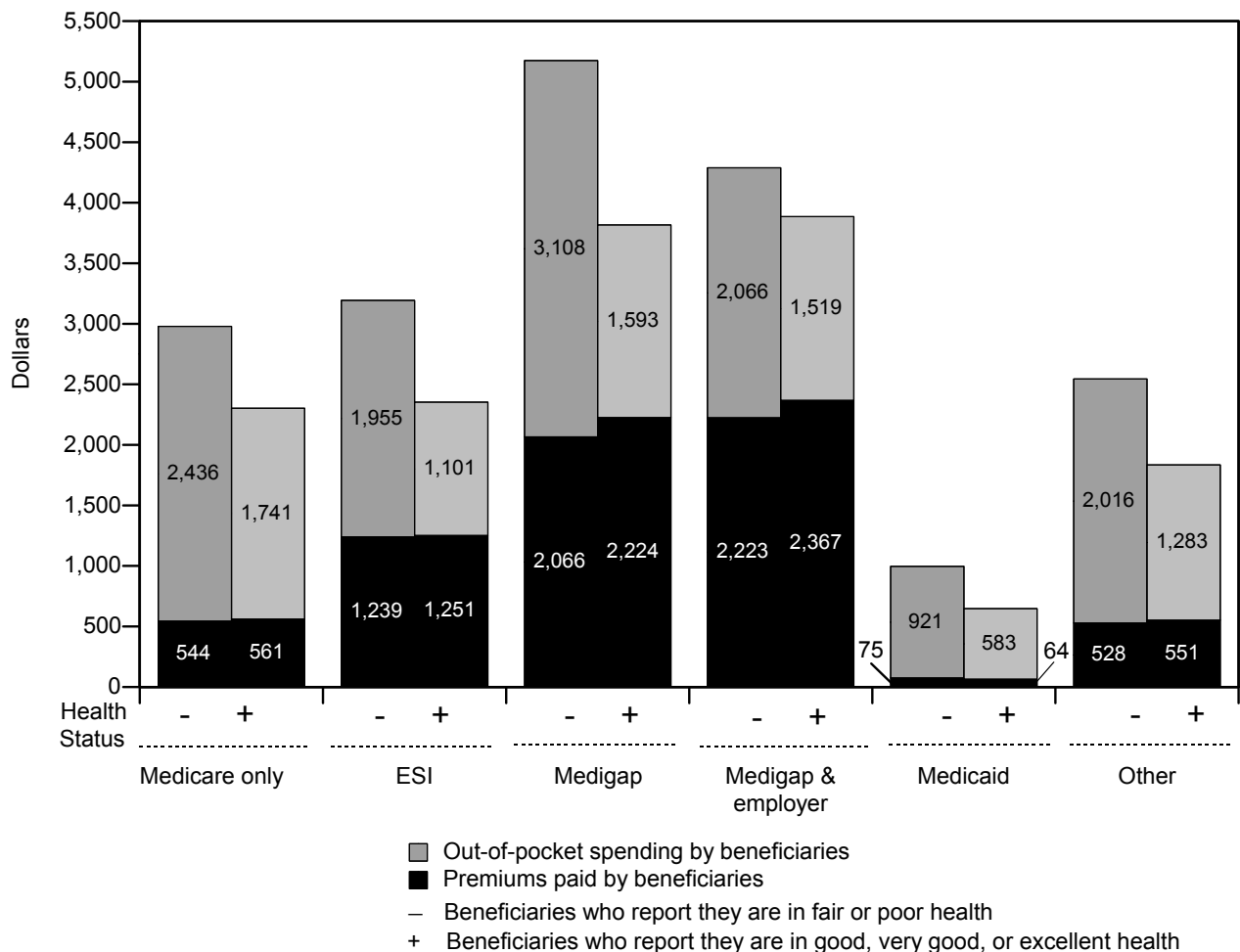


Note: FFS (fee-for-service). Beneficiaries are assigned to the supplemental coverage where they spent the most time in 2001. They could have had coverage in other categories throughout 2001. Other public sector includes federal and state programs not included in the other categories. Analysis includes only FFS beneficiaries living in the community.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use files, 2001.

- Out-of-pocket spending varies widely by a beneficiary's type of supplemental coverage. Beneficiaries with Medicaid coverage have the lowest average out-of-pocket spending, \$835. Beneficiaries with Medigap, or Medigap with employer-sponsored supplemental coverage, have the highest average out-of-pocket spending, about \$4,000.
- The composition of out-of-pocket spending differs by type of supplemental coverage. Supplemental premiums are relatively high for beneficiaries with Medigap coverage, reflecting the lack of subsidy for this type of coverage. In contrast, employers often subsidize the cost of retiree health insurance. Noncovered services are the largest component of out-of-pocket spending for beneficiaries with all categories of supplemental coverage except those who have both Medigap and employer-sponsored coverage, where supplemental premiums are the largest component.

Chart 5-10. Out-of-pocket spending for premiums and health services per beneficiary, by insurance and health status, 2001



Note: ESI (employer-sponsored supplemental insurance).

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use File, 2001.

- Insurance that supplements Medicare does not shield beneficiaries from all out-of-pocket costs. Beneficiaries who report being in fair or poor health spend more out of pocket for health services than those reporting good, very good, or excellent health, regardless of the type of coverage they have to supplement Medicare.
- What beneficiaries actually pay out of pocket varies by type of supplemental coverage. For those with Medigap, out-of-pocket spending generally reflects the premiums and costs of prescription drugs and other services not covered by Medicare. Beneficiaries with ESI usually pay less out of pocket for prescription drugs but may pay more in Medicare deductibles and cost sharing.
- Reductions in coverage and benefits offered under ESI plans, changes to Medicare benefits, and increases in premiums for all supplemental insurance since 2001, are not reflected in these data.

Web links. Medicare beneficiary and other payer financial liability

- Chapter 1 of the MedPAC June 2002 Report to the Congress provides more information on Medicare beneficiary and other payer financial liability.

http://www.medpac.gov/publications/congressional_reports/Jun2_Ch1.pdf

- Chapter 1 of the MedPAC March 2004 Report to the Congress provides more information on beneficiary and Medicare program spending as well as information about supplemental insurance.

http://www.medpac.gov/publications/congressional_reports/Mar04_Ch1.pdf

- Chapter 1 of the MedPAC March 2003 Report to the Congress provides more information on beneficiary and program spending.

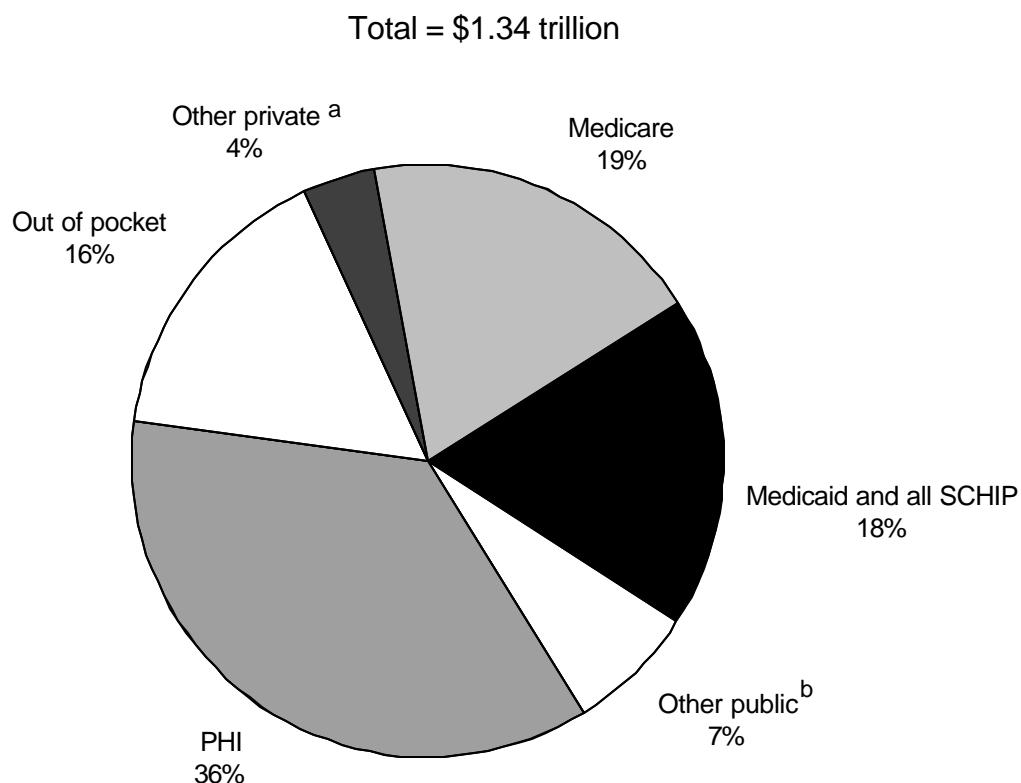
http://www.medpac.gov/publications/congressional_reports/Mar03_Ch1.pdf

SECTION

6

**National health care and
Medicare spending**

Chart 6-1. Medicare made up about one-fifth of spending on personal health care in 2002

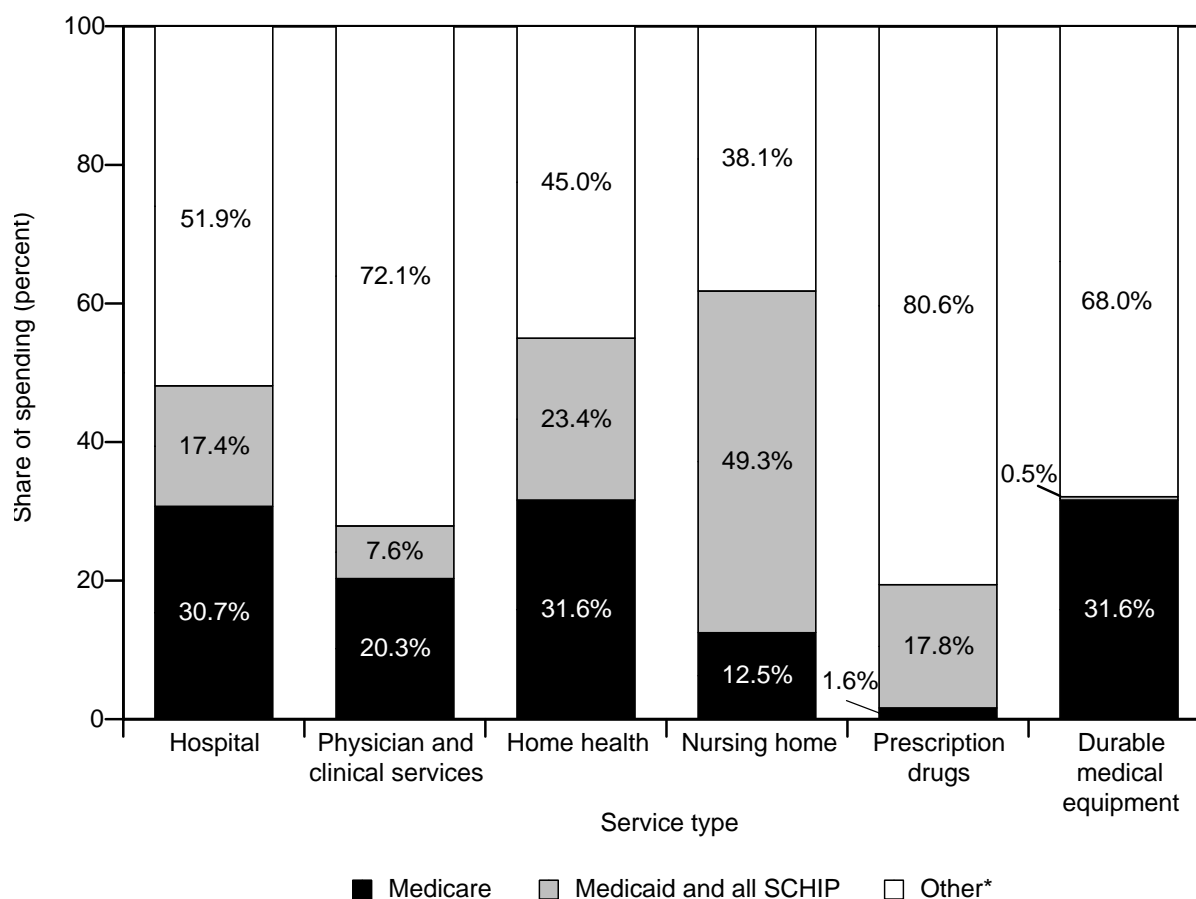


Note: PHI (private health insurance), SCHIP (State Children's Health Insurance Program). Out-of-pocket spending includes cost sharing for both privately and publicly insured individuals. Personal health spending includes spending for clinical and professional services received by patients. It excludes administrative costs and profits.
^a Includes industrial in-plant, privately funded construction, and nonpatient revenues, including philanthropy.
^b Includes programs such as workers' compensation, public health activity, Department of Defense, Department of Veterans Affairs, Indian Health Service, and state and local government hospital subsidies and school health.

Source: CMS, Office of the Actuary, National Health Accounts, 2004.

- Of the \$1.34 trillion spent on personal health care in the United States, Medicare accounts for about 19 percent or \$259 billion. Spending by all public programs, including Medicare, Medicaid, SCHIP, and other programs, accounts for 44 percent of health care spending. Medicare is the largest single purchaser of health care in the United States. Thirty-six percent of spending is from private health insurance payers and 16 percent is consumer out-of-pocket spending.
- Medicare and private health insurance spending include premium contributions from enrollees.

Chart 6-2. Medicare's share of national spending varies by type of service, 2002



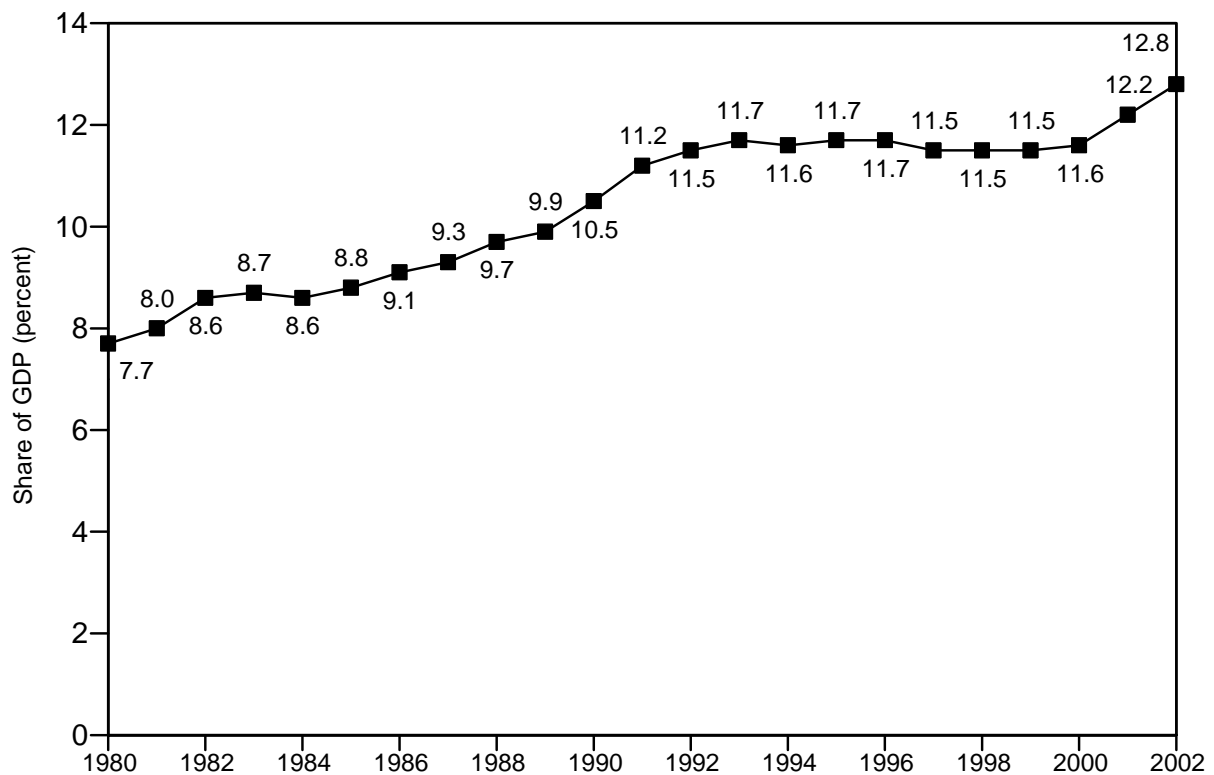
Note: SCHIP (State Children's Health Insurance Program). Personal health spending includes spending for clinical and professional services received by patients. It excludes administrative costs and profits. Totals may not sum to 100 due to rounding.

*Other includes private health insurance, out-of-pocket, and other private and public spending.

Source: CMS, Office of the Actuary, National Health Accounts, 2004.

- The level and distribution of spending differ between Medicare and other payers, largely because Medicare covers an older, sicker population, and did not cover services such as outpatient prescription drugs and long-term care during this time period.
- Medicare accounts for 30.7 and 31.6 percent of revenues for hospitals and home health agencies, respectively. In contrast, it pays for only 1.6 percent of prescription drugs and 12.5 percent of nursing home care.

Chart 6-3. Personal health care spending is increasing as a share of GDP

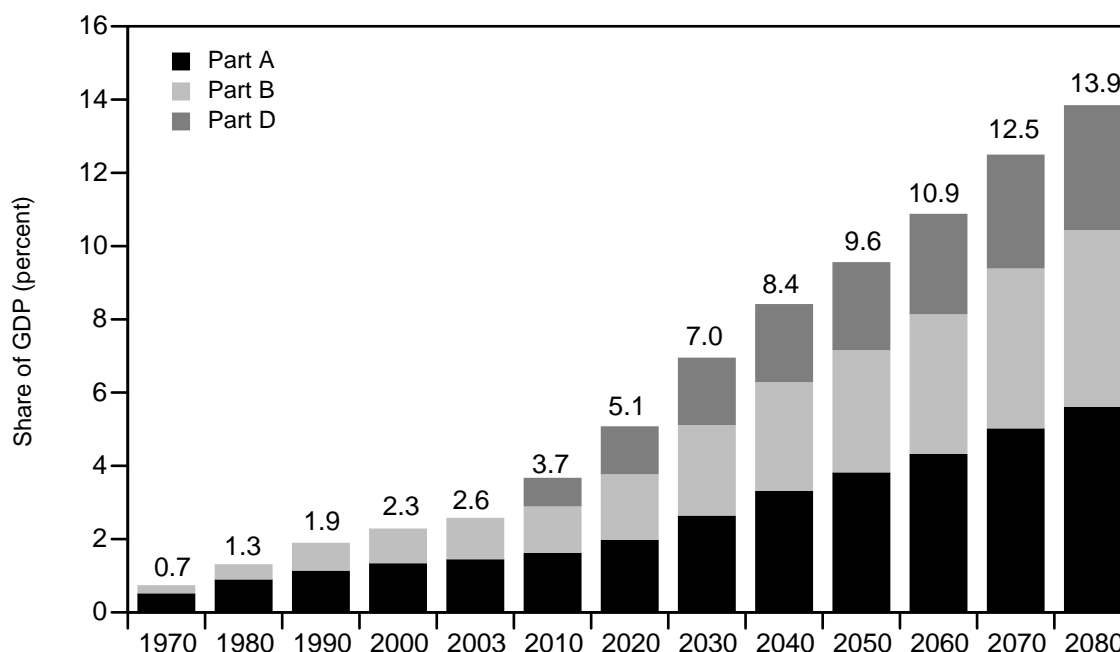


Note: GDP (gross domestic product). Personal health spending includes spending for clinical professional services received by patients. It excludes administrative costs and profits.

Source: CMS, Office of the Actuary, National Health Accounts, 2004.

- Personal health care spending consumes an increasing proportion of national resources, accounting for a double-digit share of gross domestic product (GDP) annually since 1990.
- Personal health spending as a share of GDP has increased from 7.7 percent in 1980 to a high of 12.8 percent in 2002. Stability in this proportion throughout much of the 1990s was due to slower spending growth associated with the introduction of managed care and to a strong economy.

Chart 6-4. Trustees project Medicare spending to increase as a share of GDP

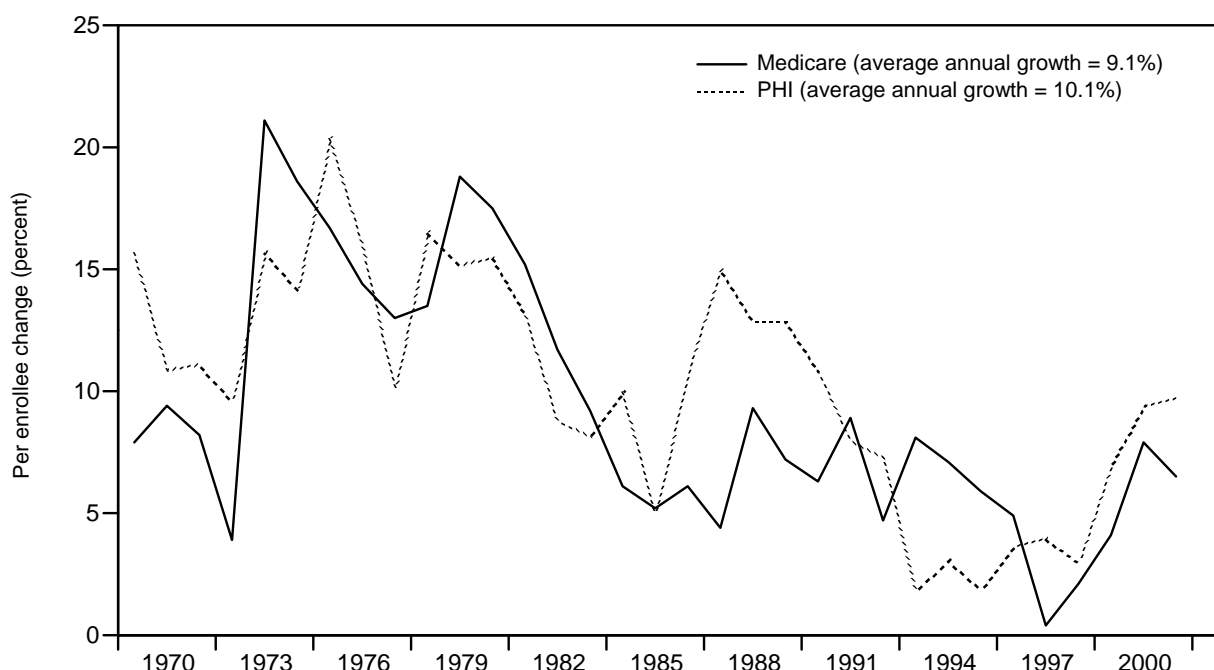


Note: GDP (gross domestic product). Trustees' data are incurred.

Source: 2004 annual report of the Boards of Trustees of the Medicare trust funds.

- Over time, Medicare spending has accounted for an increasing share of gross domestic product (GDP). From less than 1 percent in 1970, it is projected to reach 13.9 percent of GDP in 2080.
- Medicare's share of GDP increased at a faster rate in the historical period than is projected for the future. From 1980 to 2003, it grew at an average annual rate of 3.1 percent. In the projection period, Medicare's share of GDP is projected to increase steadily but at a slower pace of 2.2 percent average annual growth.
- The slower growth in Medicare's share of GDP in 2000 was due to payment reductions enacted in 1997 and faster economic growth. After 2011, the aging of the baby boom generation, an expected increase in life expectancy, and the Medicare drug benefit are expected to contribute to increases in this proportion. Additional factors such as innovation in technology also contribute to the projected rapid increases in Medicare spending as a portion of GDP.

Chart 6-5. Changes in spending per enrollee differ between Medicare and private health insurance

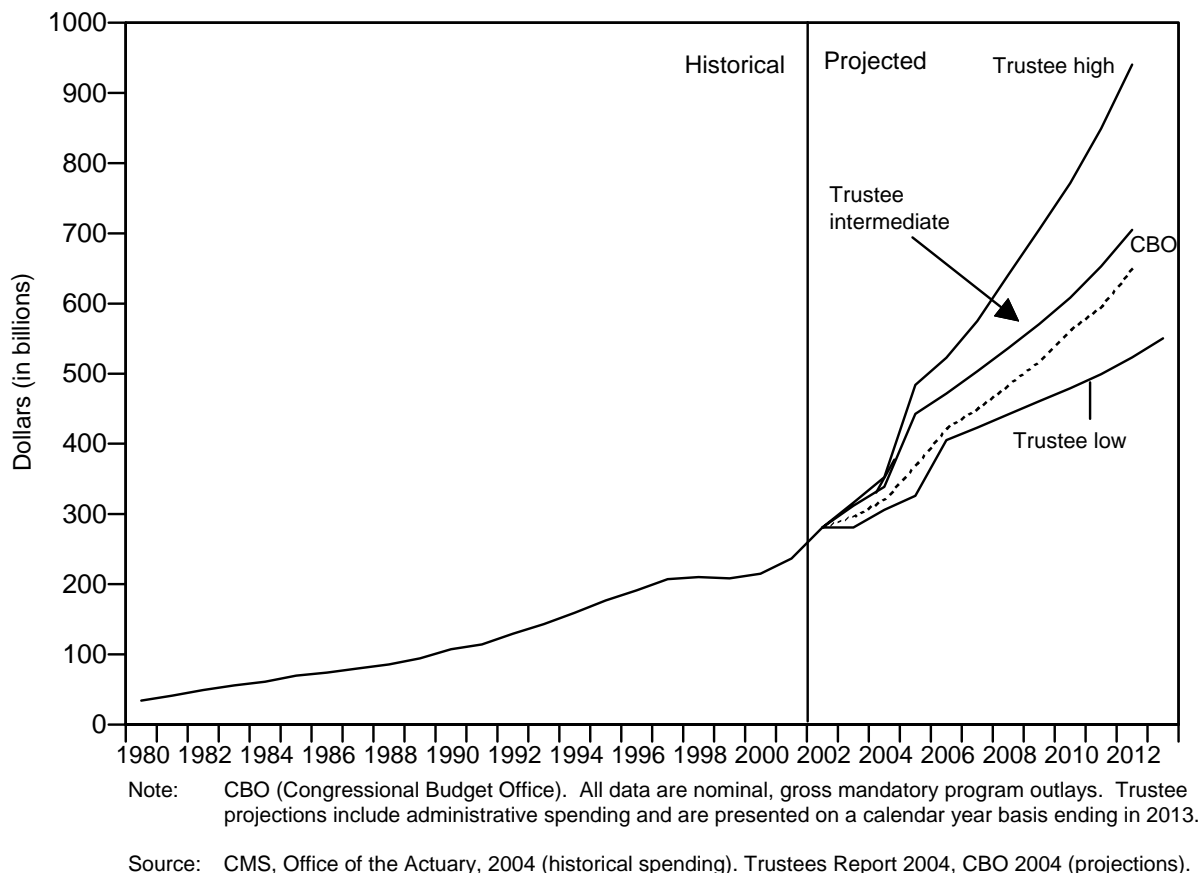


Note: PHI (private health insurance). Chart compares services covered by Medicare and PHI, including hospital services, physician and clinical services, other professional services, and durable medical products.

Source: Heffler, S., S. Smith, S. Keehan, et al. 2004. Health spending projections through 2013. *Health Affairs Web Exclusives* (February 11). <http://www.healthaffairs.org>.

- Over a 32-year period, despite some fluctuation, Medicare's average per enrollee growth rate has been slightly lower over the long term than the average for private health insurance. This may reflect the effects of the program's size and policies that hold down spending, such as the provisions in the Balanced Budget Act of 1997. After adjustment for comparable benefits, national health accounts data show that the average annual per enrollee Medicare growth over this period was 9.1 percent, compared to 10.1 percent for private health insurance.
- This comparison is imperfect, however, and should be considered with an appreciation for its limitations. Private insurers and Medicare do not buy the same mix of services, and Medicare covers an older population that tends to be more costly. For example, Medicare spending on services provided by home health agencies and skilled nursing facilities grew rapidly in the 1990s, but these services generally are a small part of benefits paid by private insurers. In addition, the data do not allow analysis of the extent to which spending trends were affected by changes in the generosity of covered benefits and, in turn, enrollees' cost-sharing burden.
- A discussion on comparing Medicare and private health insurance growth can be found in Chapter 1 of the MedPAC March 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/Mar04_Ch1.pdf.

Chart 6-6. Trustees and CBO project Medicare growth rate of about 10 percent over next 10 years

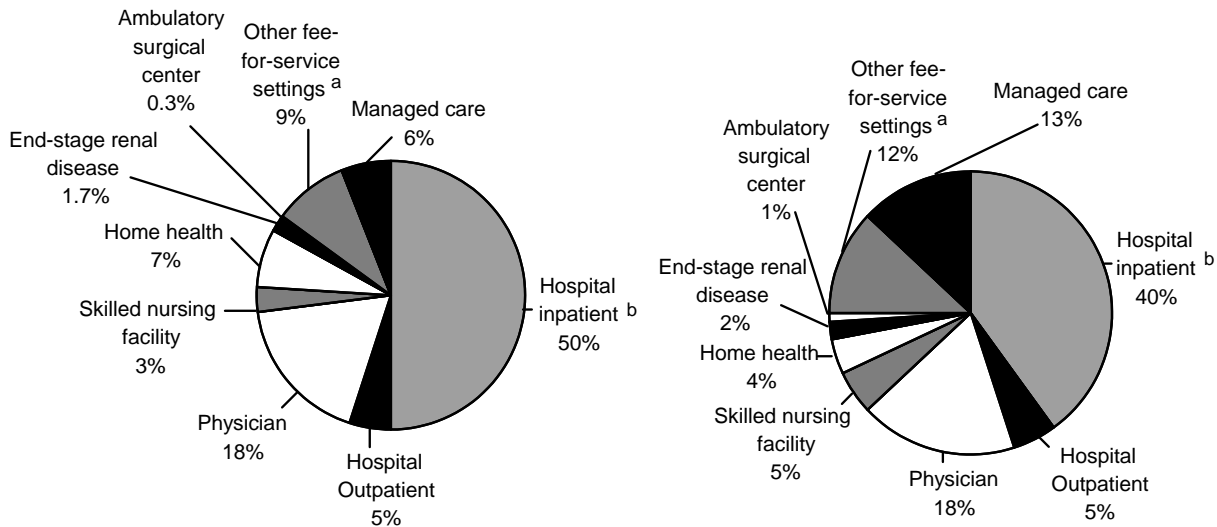


- Medicare spending has grown more than eight fold, from \$33.9 billion in 1980 to \$272.4 billion in 2003.
- Between 1980 and 1997, Medicare spending grew rapidly, increasing 11.1 percent annually on average. Following passage of the Balanced Budget Act of 1997, which reduced Medicare provider payment rates, this rate of increase declined sharply, to about 2 percent average annual growth between 1997 and 2000. Subsequent legislation restored some of the payment reductions and this, in part, accounts for spending increases of 10.1, 6.6, and 4.9 percent in 2001, 2002, and 2003, respectively.
- CBO projects that mandatory spending for Medicare will grow at an average annual rate of 10.1 percent from 2004 to 2014. The Medicare Trustees' intermediate projection for 2003 to 2013 assumes 10.8 percent average annual growth. Forecasts of future Medicare spending are inherently uncertain, and differences can stem from different assumptions about the economy (which affect provider payment annual updates) and growth in volume and intensity of services delivered to Medicare beneficiaries, among other factors.

Chart 6-7. Medicare spending is concentrated in certain services and has shifted over time

Total spending 1993 = \$143 billion

Total spending 2003 = \$272 billion



Note: Spending numbers are presented as gross outlays, meaning that they include spending financed by beneficiary premiums but do not include spending by beneficiaries (or on their behalf) for cost sharing associated with Medicare-covered services. They are reported on a fiscal year, incurred basis and do not include spending on program administration. Totals may not sum to 100 due to rounding.

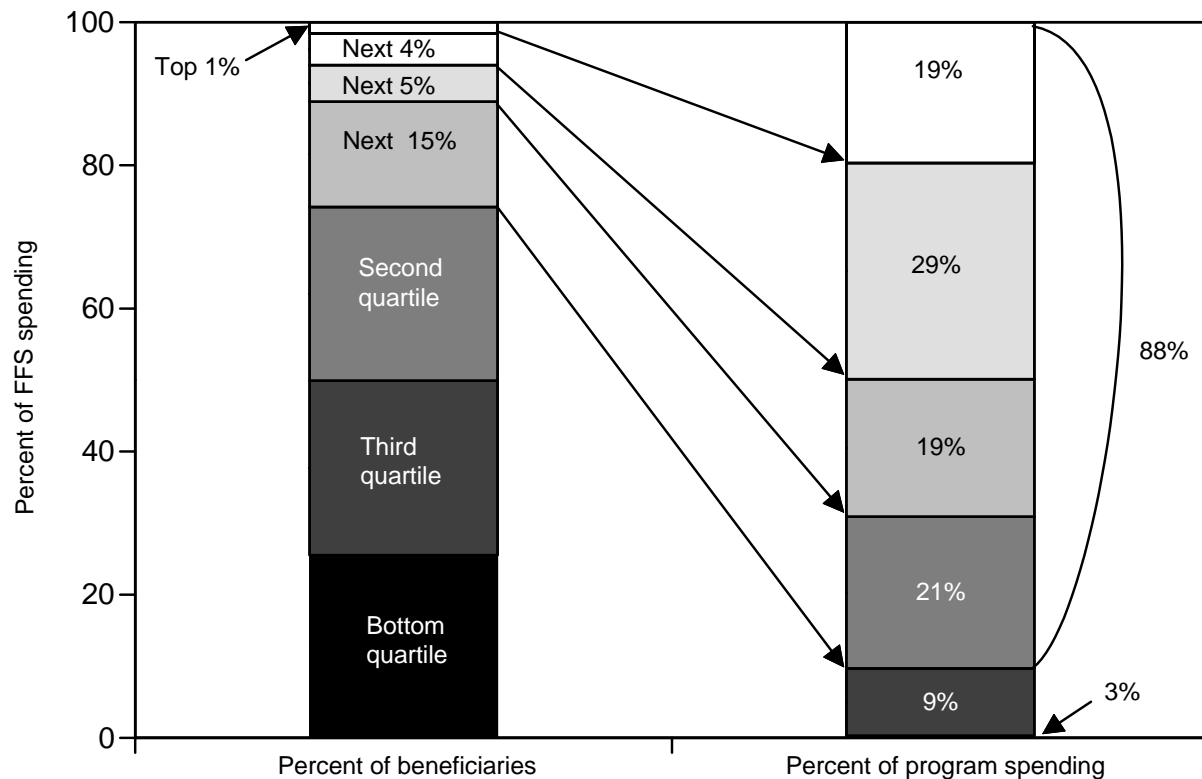
^a Includes hospice; outpatient laboratory; durable medical equipment; physician-administered drugs, ambulance service, and supplies; and rural health clinics, federally qualified health centers, and outpatient rehabilitation facilities.

^b Includes all hospitals, those paid under the prospective payment system (PPS), and PPS-exempt hospitals.

Source: CMS, Office of the Actuary, 2004 Mid-Session Review.

- Medicare spending is concentrated on certain services, and the distribution among services or settings can vary substantially over time.
- In 2003, Medicare spent about \$272 billion, or \$6,647 per enrollee. Inpatient hospital services were by far the largest spending category (40 percent), followed by physicians (18 percent), managed care (13 percent), and other fee-for-service settings (12 percent).
- Although inpatient hospital services still comprise the largest spending category, the category has shrunk as a percentage of Medicare spending, falling from 50 to 40 percent. Spending on beneficiaries enrolled in managed care has grown from 6 to 13 percent over this period. While the number of beneficiaries enrolled in managed care plans has declined recently, current enrollment remains higher than it was a decade ago.

Chart 6-8. Medicare spending is concentrated among a small group of beneficiaries



Note: FFS (fee-for-service). Reflects concentration in spending in 2002. Based on a 0.1 percent sample file of Medicare FFS beneficiaries and their claims.

Source: Direct Research, LLC.

- Medicare fee-for-service (FFS) spending is concentrated among a small number of beneficiaries. In 2002, the costliest 5 percent of beneficiaries accounted for 48 percent of annual Medicare FFS spending and the costliest quartile accounted for 88 percent. By contrast, the least costly half of beneficiaries accounted for only 3 percent of FFS spending.
- Costly beneficiaries tend to include those that have multiple chronic conditions, those using inpatient hospital care, and those who are in the last year of life.
- Further discussion of this analysis can be found in chapter 2 of the MedPAC June 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/June04_ch2.pdf.

Chart 6-9. Medicare HI trust fund is projected to be insolvent in 2019

Estimate	Year costs exceed income	Year HI trust fund assets exhausted
High	2005	2012
Intermediate	2010	2019
Low	*	2055

Note: HI (hospital insurance). Income includes taxes (payroll and Social Security benefits taxes, Railroad Retirement tax transfer), income from the fraud and abuse program, and interest from trust fund assets.

*Not available

Source: 2004 annual report of the Boards of Trustees of the Medicare trust funds. CMS, Office of the Actuary.

- The Medicare program is financed through two trust funds: The Hospital Insurance (HI) trust fund and the Supplementary Medical Insurance (SMI) trust fund. Unlike the SMI fund, the HI trust fund can be exhausted if spending exceeds revenue plus reserves. The HI trust fund is, by law, separate from general revenues. Its receipts come primarily from current payroll taxes and interest earnings on assets held by the trust fund, with the remainder from beneficiary premiums, income taxes on social security benefits, and other sources. The SMI trust fund is financed by general revenue and beneficiary premiums and cannot be exhausted.
- The financial status of the HI fund has deteriorated significantly and is projected to become insolvent in 2019 under the Trustees' intermediate estimate, seven years earlier than projected in the 2003 Trustees' report. Costs are projected to exceed tax revenues in 2010. This change results from several factors: The Medicare drug legislation, higher HI expenditures and lower payroll tax revenues in 2003 than expected, improved data on the health status of beneficiaries in HMOs, and model refinements for certain hospital payments.
- Under high cost assumptions, the HI trust fund could be exhausted as early as 2012. Under low cost assumptions, it would remain solvent until 2055.

Chart 6-10. Medicare FFS providers: Spending, supply and projected growth rates

Provider	Number of spending providers 2003	Program projection of FY 2003 (billions)
Inpatient PPS for acute-care hospitals	4,038	\$ 101.4
Other hospitals	2,019 ^a	7.9
Hospital outpatient PPS	3,958 ^b	13.0
Physicians	506,594	48.3
Skilled nursing facilities	14,918	14.7
Home health agencies	7,314	9.9
Hospices	2,454	5.9
Ambulatory surgical centers	3,735	1.8
Free-standing dialysis facilities	4,132	5.9
Outpatient clinical laboratories	183,874	5.4
Durable medical equipment suppliers	~50,000	5.6

Note: FFS (fee-for-service), FY (fiscal year), PPS (prospective payment system). Data include program spending only and do not include cost-sharing.

^aIncludes specialty hospitals such as psychiatric, rehabilitation, children's, cancer, and long-term care hospitals, as well as critical access hospitals and short-stay hospitals in Maryland.

^bDoes not include long-term, alcohol and drug abuse, and critical access hospitals, but does include psychiatric, rehabilitation, and children's hospitals that bill under the outpatient PPS.

Source: Number of providers comes from a variety of CMS database as of years 2002–2004, including the Provider of Service file; the Online Survey, Certification, and Reporting File; the standard Analytical File; the CMS data compendium; the CMS website; and unpublished CMS data.

- The most numerous Medicare providers are physicians, followed by outpatient laboratories and durable medical equipment suppliers.

Web links. National health care and Medicare spending

- The Trustees' Report provides information on the financial operations and actuarial status of the Medicare program.

<http://www.cms.hhs.gov/publications/trusteesreport>

- The National Health Accounts at CMS provide information and research on spending for health care in the U.S.

<http://cms.hhs.gov/statistics/nhe/default.asp>

- The CMS Chart series provides information on the U.S. health care system and the Medicare program spending.

<http://www.cms.gov/charts>

S E C T I O N

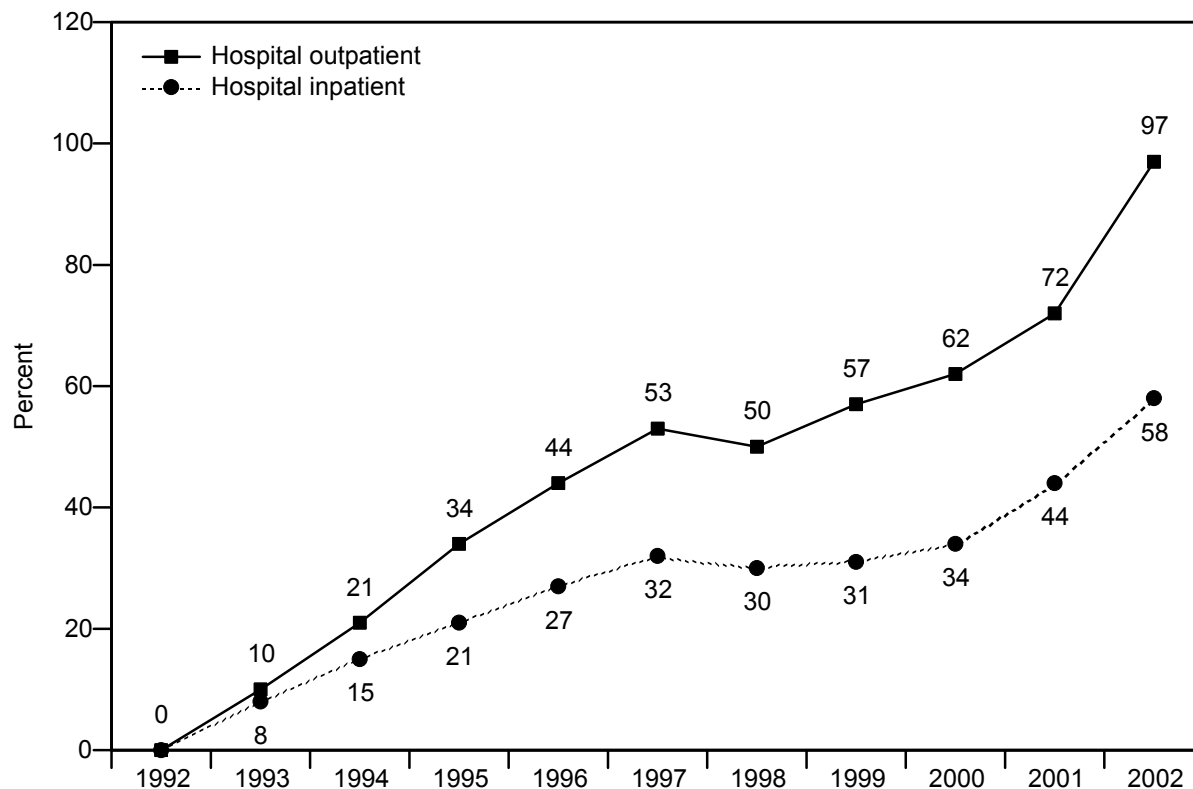
7

Acute inpatient services

Short-term hospitals

Specialty psychiatric facilities

Chart 7-1. Cumulative percentage change in Medicare hospital inpatient and outpatient spending, fiscal years 1992–2002



Note: Cumulative change is the total percent increase from 1992 to the year indicated. Includes inpatient services covered by the acute inpatient prospective payment system (PPS) and psychiatric, rehabilitation, long-term care, cancer, and children's hospitals and units; includes outpatient services covered by the PPS and other outpatient services. Payments include both program outlays and cost sharing incurred by beneficiaries.

Source: CMS, Office of the Actuary.

- Medicare hospital inpatient spending increased 58 percent (4.7 percent per year) and outpatient spending 97 percent (7.0 percent per year) from fiscal year (FY) 1992 to FY 2002. A freeze in inpatient payment rates in the Balanced Budget Act of 1997 (BBA), combined with lower Medicare discharges, reduced inpatient spending in 1998. Higher Medicare discharges, a higher update, case mix change, and expansion of disproportionate share payments increased inpatient spending in 2001 and 2002. Outpatient spending fell in 1998, reflecting the BBA's elimination of inadvertent overpayments. Transitional corridor payments and new technology payments in the outpatient prospective payment system, along with volume increase, increased outpatient spending in 2001 and 2002.
- Aggregate Medicare inpatient spending was \$113 billion and outpatient spending was \$22 billion in FY 2002.

Chart 7-2. Diagnosis related groups with highest volume, fiscal year 2003

DRG number	DRG name	Percentage of discharges	Number of discharges (thousands)
127	Heart failure and shock	6%	693
89	Simple pneumonia and pleurisy age > 17 with cc	4	519
209	Major joint and limb reattachment procedures of lower extremity	4	427
88	Chronic obstructive pulmonary disease	3	397
182	Esophagitis, gastroenteritis, and miscellaneous digestive disorders age > 17 with cc	2	292
296	Nutritional and miscellaneous metabolic disorders age > 17 with cc	2	261
174	GI hemorrhage with cc	2	259
143	Chest pain	2	246
14	Intracranial hemorrhage or cerebral infarction	2	242
320	Kidney and urinary tract infections age > 17 with cc	2	211
Total Medicare discharges		100	11,900

Note: DRG (diagnosis related group), cc (complication or comorbidity), GI (gastrointestinal).

Source: Federal Register, May 18, 2004, p. 28195–28818. Available at <http://www.gpoaccess.gov/fr/index.html>.

- In fiscal year 2003, 10 diagnosis related groups (DRGs) accounted for 30 percent of discharges from hospitals paid under the acute inpatient prospective payment system.
- Medicare inpatient cases are assigned to 516 DRGs based on discharge diagnoses, procedures performed, age, sex, discharge destination, and presence of complications or comorbidities.

Chart 7-3. Number of hospitals and Medicare discharges, by hospital group, 2002

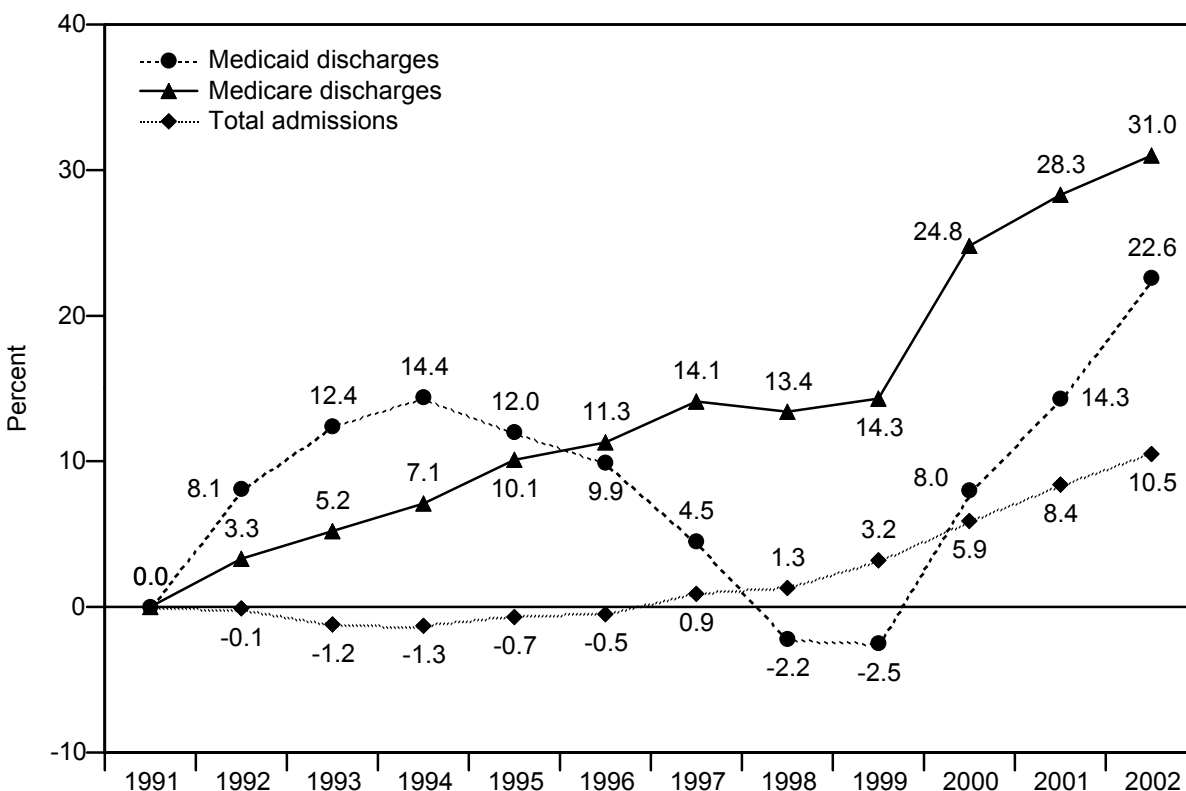
Hospital group	Hospitals		Medicare discharges	
	Number	Share of total	Number (thousands)	Share of total
All hospitals	3,996	100.0%	10,916	100.0%
Urban	2,517	63.0	8,852	81.1
Rural	1,479	37.0	2,063	18.9
Large urban	1,461	36.6	5,051	46.3
Other urban	1,056	26.4	3,801	34.8
Rural referral	239	6.0	836	7.7
Sole community	494	12.4	493	4.5
Small rural Medicare-dependent	254	6.4	204	1.9
Other rural < 50 beds	244	6.1	147	1.3
Other rural ≥ 50 beds	248	6.2	384	3.5
Voluntary	2,410	60.3	8,003	73.3
Proprietary	737	18.4	1,552	14.2
Government	809	20.2	1,350	12.4
Major teaching	290	7.3	1,586	14.5
Other teaching	813	20.3	3,779	34.6
Nonteaching	2,893	72.4	5,550	50.8

Note: Analysis includes all hospitals covered by Medicare's acute inpatient prospective payment system. Critical access hospitals, hospitals in Maryland, and care paid for through other payment systems (those for long-term care hospitals, rehabilitation facilities, and psychiatric facilities) are excluded. Large urban areas have populations over 1 million. Major teaching hospitals are defined by a ratio of interns and residents to beds of at least .25, while other teaching hospitals have a ratio of below .25.

Source: MedPAC analysis of Medicare cost report data (third quarter 2003) from CMS.

- In 2002, 3,996 hospitals provided 10.9 million discharges under Medicare's acute inpatient prospective payment system.
- Almost two-thirds of the hospitals are located in urban areas, and about 60 percent are voluntary (non-profit, non-government). Major teaching hospitals compose 7 percent of the hospitals but provide 15 percent of the care. About a quarter of hospitals are covered by special payment provisions intended to help rural hospitals (the rural referral, sole community, and small rural Medicare-dependent hospitals), but these facilities provide only 14 percent of the discharges.

Chart 7-4. Cumulative percentage change in Medicare, Medicaid, and total hospital admissions, 1991–2002

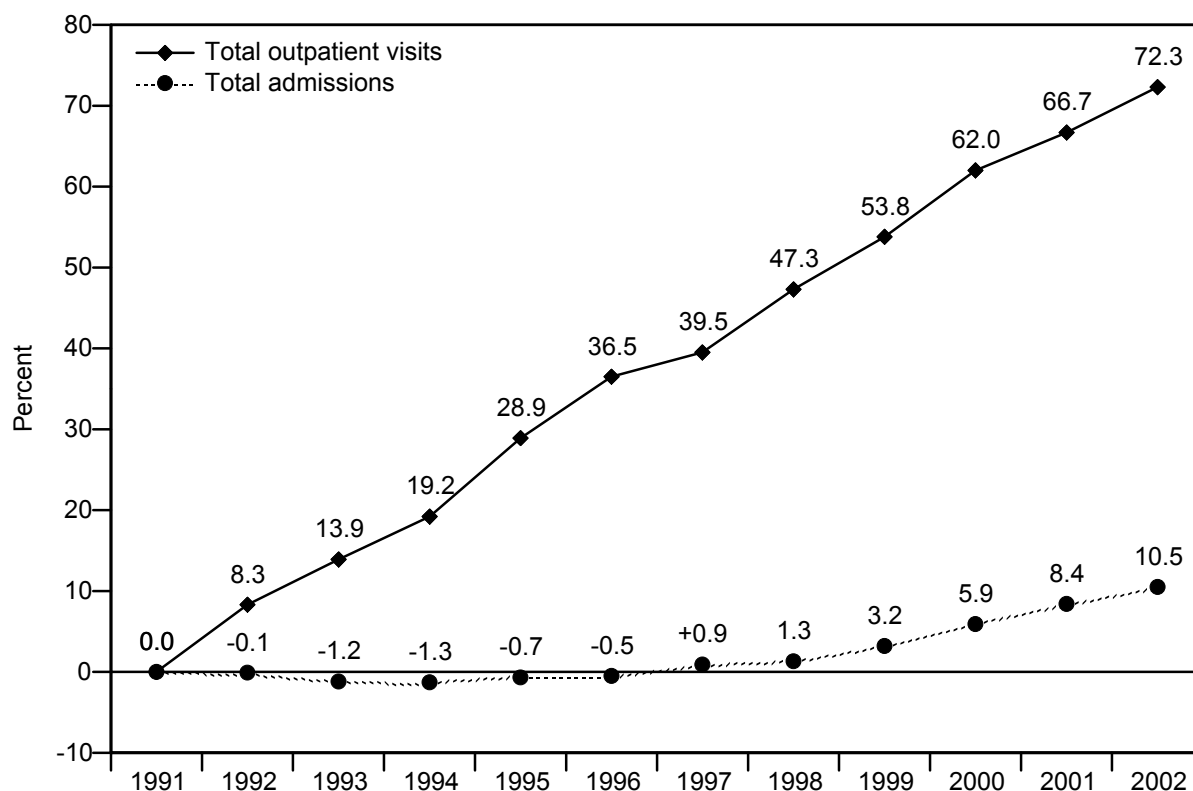


Note: Cumulative change is the total percentage increase from 1991 to the year indicated. Data are admissions to and discharges from approximately 5,000 community hospitals, excluding nursing home units. Medicare discharges include acute inpatient, psychiatric, rehabilitation, long-term care, cancer, and children's hospitals and units.

Source: American Hospital Association annual survey of hospitals.

- Total hospital admissions fell 1 percent from 1991 through 1994 and increased 12 percent through 2002 for a total increase of 11 percent from 1991 to 2002. Medicare discharges grew every year except 1998, increasing by 31 percent from 1991 to 2002. This increase surpassed the rate of growth in Medicare beneficiaries by 13 percent. Medicaid discharges increased 14 percent from 1991 to 1994 and declined 15 percent through 1999 before increasing 26 percent through 2002. This reflected eligibility expansions that increased Medicaid enrollment by 46 percent from 1990 to 1995, followed by a 2 percent drop in enrollment through 2000 and a 9 percent rise through 2002.
- Total admissions were 35 million, Medicare discharges were 14 million, and Medicaid discharges were 6 million in 2002.

Chart 7-5. Cumulative change in total admissions and total outpatient visits, 1991–2002

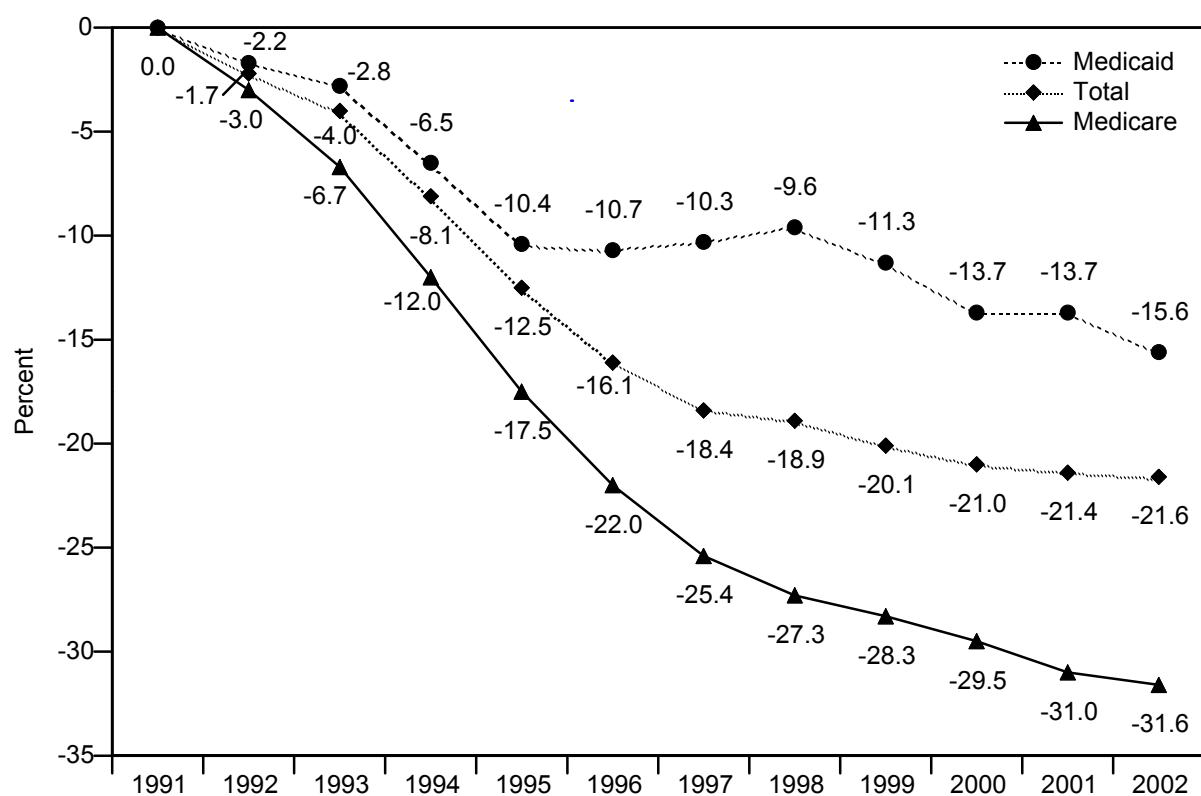


Note: Cumulative change is the total percent increase from 1991 through the year indicated. Data are admissions to approximately 5,000 community hospitals, excluding nursing home units.

Source: American Hospital Association annual survey of hospitals.

- Hospital outpatient service use has grown much more rapidly than inpatient service use. Total hospital outpatient visits increased 72 percent from 1991 to 2002, with increases exceeding 4 percent in every year except 1997, 2001, and 2002. Total admissions grew more slowly than outpatient visits, increasing just 11 percent from 1991 to 2002.
- There were 561 million outpatient visits and 35 million admissions to community hospitals in 2002.

Chart 7-6. Cumulative change in Medicare, Medicaid, and total hospital inpatient length of stay, 1991–2002

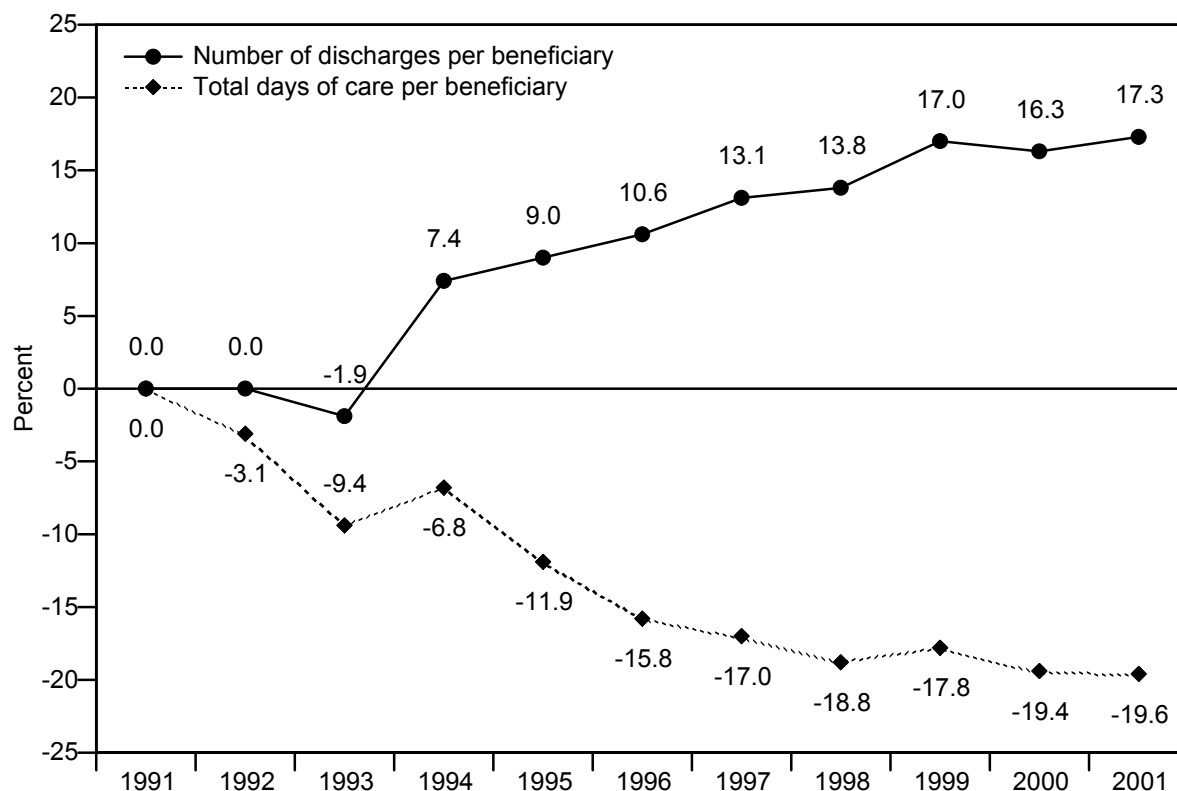


Note: Cumulative change is the total percent increase from 1991 to the year indicated. Length of stay is calculated from admissions or discharges and patient days for approximately 5,000 community hospitals, excluding nursing home units.

Source: American Hospital Association annual survey of hospitals.

- Length of stay for all hospital inpatient admissions fell by 22 percent to 5.1 days and for Medicare inpatients by 32 percent to 6.0 days from 1991 to 2002, with rates of decline slowing after 1995. Medicaid length of stay fell 16 percent to 5.2 days over this period, with increases in 1997 and 1998.

Chart 7-7. Cumulative change in Medicare inpatient days per beneficiary and discharges per beneficiary, 1991–2001



Note: Cumulative change is the total percentage increase from 1991 to the year indicated. Data are short-stay hospital Medicare patient days and discharges. Rate is per beneficiary enrolled in Part A. Beginning with 1994 data, the statistics do not reflect managed care enrollment.

Source: MedPAC analysis of data from CMS.

- While discharges per beneficiary have increased, length of stay has fallen. Medicare hospital use rates increased from 1991 to 2001, with 17 percent more hospital discharges per enrollee at the end of the period. However, declining length of stay led to 20 percent fewer days of inpatient care for each enrollee in 2001 compared to 1991.
- There were 366 Medicare hospital discharges and 2,171 patient days per 1,000 beneficiaries enrolled in Part A in fiscal year 2001.
- Beginning in 1994, the number of beneficiaries excludes managed care enrollees, increasing the rate per 1,000 beneficiaries enrolled in Part A (see Chart 12-2).

Chart 7-8. Simulated Medicare inpatient payments, by component and hospital group, reflecting payment policy under the MMA

Hospital group	Percent of total payments					Total payments (millions)
	Base	Indirect medical education	Disproportionate share	Outlier	Additional rural hospital*	
All hospitals	82.9%	5.0%	6.9%	3.5%	1.7%	93,200
Urban	82.7	5.7	7.5	3.9	0.2	79,666
Rural	83.8	0.6	4.0	1.1	10.6	13,534
Large urban	80.8	7.1	7.9	4.1	0.0	47,912
Other urban	85.5	3.7	6.7	3.6	0.4	31,754
Rural referral	85.5	1.2	4.1	1.7	7.5	6,072
Sole community	71.1	0.0	1.7	0.3	26.9	3,558
Small rural Medicare-dependent	94.2	0.0	3.6	0.4	1.9	1,012
Other rural < 50 beds	93.4	0.0	6.1	0.5	0.0	732
Other rural ≥ 50 beds	91.8	0.1	6.8	1.4	0.0	2,160
Voluntary	83.6	5.4	6.1	3.5	1.4	69,503
Proprietary	85.2	1.7	9.0	3.1	1.0	12,251
Government	76.1	6.1	10.2	3.7	3.9	11,359
Major teaching	67.8	16.7	10.0	5.4	0.1	20,308
Other teaching	85.1	3.8	6.7	3.7	0.7	33,313
Nonteaching	88.6	0.0	5.6	2.4	3.3	39,579

Note: MMA (Medicare Prescription Drug, Improvement, and Modernization Act of 2003). Analysis includes all hospitals covered by Medicare's acute inpatient prospective payment system (PPS). Critical access hospitals, hospitals in Maryland, and care paid for through other payment systems (those for long-term care hospitals, rehabilitation facilities, and psychiatric facilities) are excluded. Simulated payments reflect 2004 payment rules as amended by provisions of the MMA applied to actual number of cases in 2002. Actual payments in 2004 will likely be higher than shown due to growth in number of cases.

* Payments received by sole community and Medicare-dependent hospitals beyond what would have been received under PPS. A few sole community hospitals are located in urban areas.

Source: MedPAC analysis of claims and impact file data from CMS.

- If the prospective payment system (PPS) discharges that hospitals furnished in 2002 had been paid for under current payment policies, reflecting the provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), then Medicare would have spent \$93.2 billion. This total is composed of base diagnosis related group payments (82.9 percent); indirect medical education (IME) payments (5.0 percent); disproportionate share (DSH) payments (6.9 percent); outlier payments (3.5 percent); and additional payments to rural hospitals through the sole community and Medicare-dependent programs (1.7 percent).
- Urban hospitals receive most of the IME, DSH and outlier payments, but rural hospitals receive almost all of the extra payments from the sole community and Medicare-dependent programs. The extra amounts from these four programs combined account for 16.7 percent of payments for urban hospitals and 15.6 percent for rural hospitals.
- Major teaching hospitals have the largest share of payments coming from outlier payments (5.4 percent).
- The increase in payments resulting from MMA provisions, along with other policy changes occurring between 2002 and 2004, are highlighted in Chart 7-18.

Chart 7-9. Composition of the hospital market basket

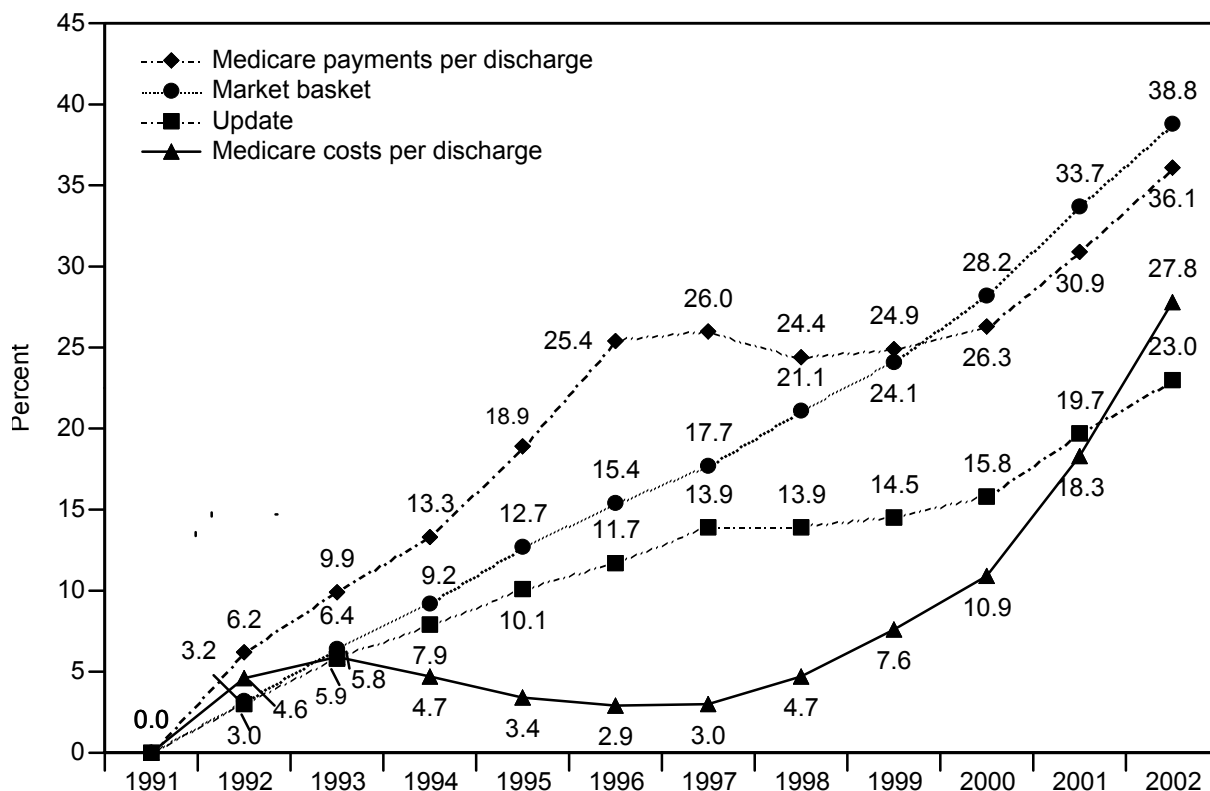
Input	Weight (share of total)		Forecasted price changes for 2005
	Subcategory	Category	
Total	N/A	100.0%	3.3%
Compensation	N/A	61.7	3.6
Wages and salaries	50.7%	N/A	3.5
Employee benefits	11.0	N/A	4.2
Professional fees	N/A	5.4	3.4
Utilities	N/A	1.4	-2.7
Malpractice insurance	N/A	0.8	6.8
All other	N/A	30.7	2.6
Other products	19.5	N/A	2.6
Other services	11.2	N/A	2.6

Note: N/A (not available). The table omits subcategories of utilities, all other products, and all other services.

Source: Global Insight, Health-Care Cost Review, First Quarter 2004, Exhibit 6.1, Table 6.1FY.

- CMS and the Congress use forecasts of the hospital market basket, a measure of the input prices paid by hospitals, to update payment rates. Over half of hospital operating costs, as measured by the market basket, are for labor expenses, and are expected to increase 3.6 percent in fiscal year 2005, more rapidly than growth in prices for other products and services. The forecast for the overall market basket is 3.3 percent.
- The hospital market basket reflects costs for hospitals paid under the acute inpatient prospective payment system. A CMS contractor prepares forecasts of price indexes that measure price changes for the market basket cost categories.
- A discussion of the components of recent hospital cost growth can be found in Chapter 3A of the MedPAC March 2004 report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3A.pdf.

Chart 7-10. Cumulative change in Medicare hospital PPS inpatient payments and costs per case, hospital market basket index, and PPS operating update, 1991–2002

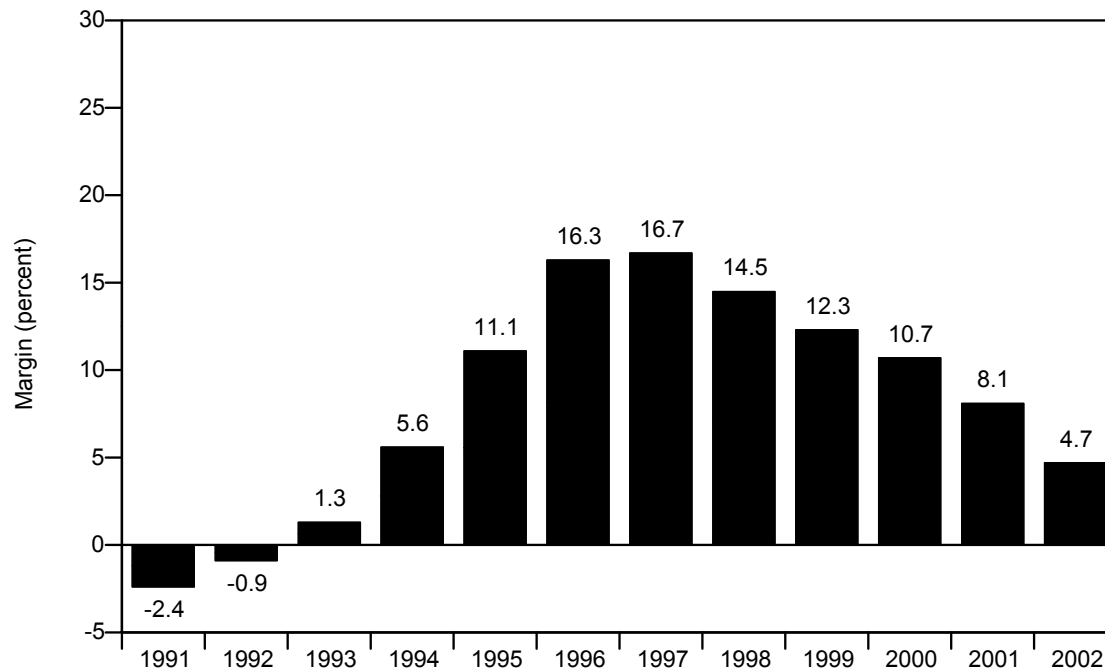


Note: PPS (prospective payment system). Cumulative change is the total percent increase from 1991 to the year indicated.

Source: MedPAC analysis of Medicare cost report data and market basket data from CMS.

- Medicare payments per discharge increased 36.1 percent from 1991 to 2002, less than the increase in the hospital market basket (38.8 percent), but significantly more than the rise in hospitals' costs per discharge (27.8 percent).
- The cumulative update increased inpatient prospective payment system operating payment rates 23 percent from 1991 to 2002, which is 4.8 percentage points less than hospitals' cost growth. However, hospitals' payment increases have exceeded the updates (due mostly to increases in case mix) and consequently payments have risen 8 percentage points more than costs. Hospital costs grew more slowly than the market basket increase before 2001 primarily because of reduced average length of stay.

Chart 7-11. Medicare acute inpatient PPS margins, 1991–2002

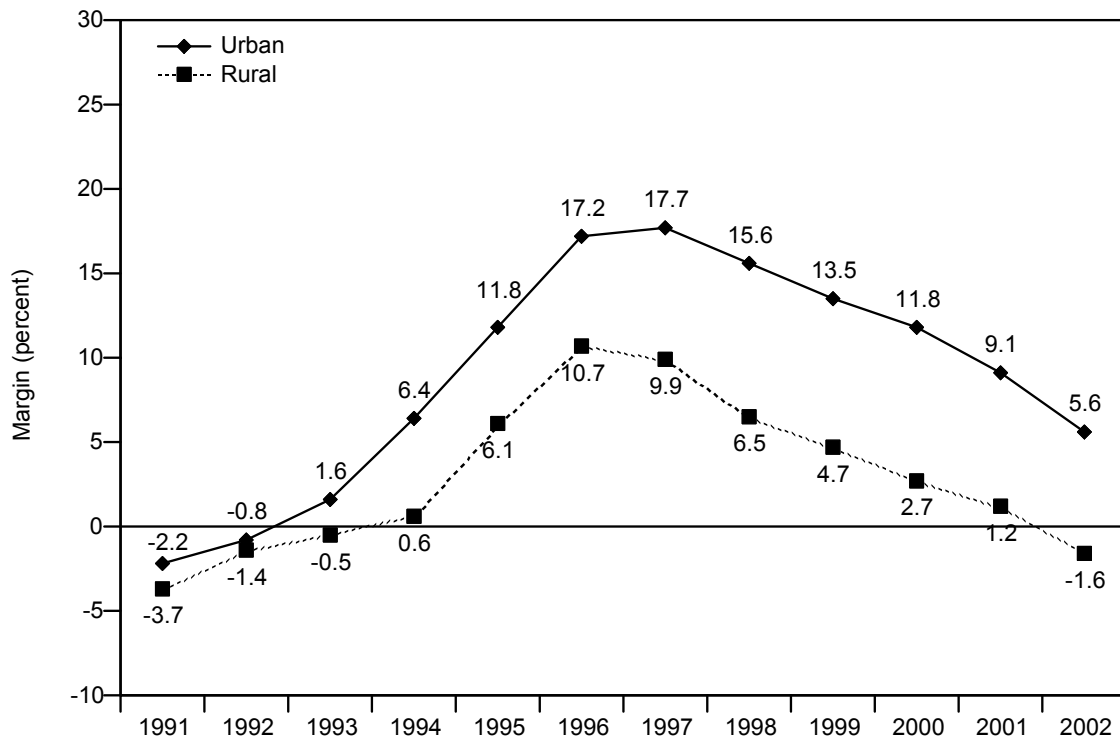


Note: PPS (prospective payment system). A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and imputed for hospitals for which 2002 cost reports were not available. Analysis excludes critical access hospitals. Medicare acute inpatient PPS margin includes services covered by the acute care inpatient PPS.

Source: MedPAC analysis of Medicare cost report data (third quarter 2003) from CMS.

- The Medicare's inpatient margin reflects payments and costs for services covered by Medicare's inpatient hospital prospective payment system (PPS). In the past, hospitals had a strong incentive to shift costs from settings under prospective payment (i.e., acute inpatient PPS) to settings paid on a cost basis (i.e., outpatient and post-acute care services). Consequently, inpatient service margins are probably biased upward and outpatient and hospital-based post-acute care service margins are probably biased downward.
- The Medicare inpatient margin increased steadily from 1991 through 1997, from a low of –2.4 percent to a record high of 16.7 percent. After implementation of the Balanced Budget Act of 1997, inpatient margins fell. In 2002, the margin was 4.7 percent.

Chart 7-12. Medicare acute inpatient PPS margins, by urban and rural location, 1991–2002

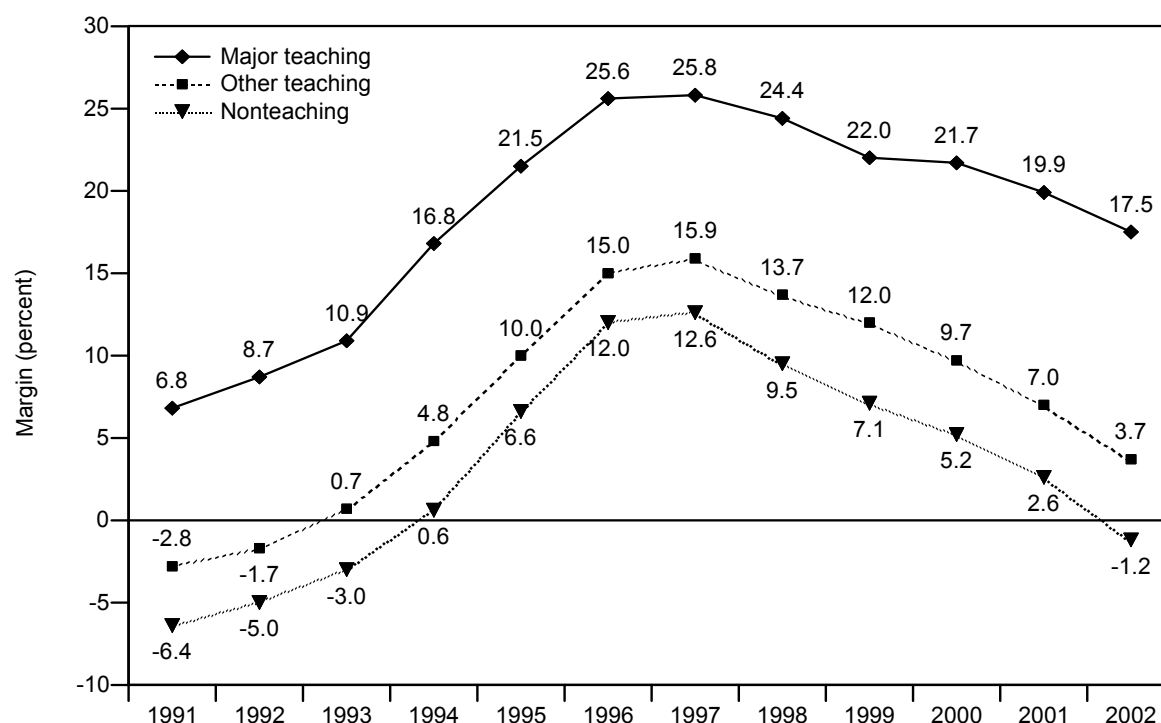


Note: PPS (prospective payment system). A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and imputed for hospitals for which 2002 cost reports were not available. Analysis excludes critical access hospitals. Medicare acute inpatient PPS margin includes services covered by the acute care inpatient PPS.

Source: MedPAC analysis of Medicare cost report data (third quarter 2003) from CMS.

- Medicare inpatient margins have consistently been higher for urban hospitals than for rural hospitals. A large part of this difference in financial performance can be explained by special payments, such as the disproportionate share and indirect medical education adjustments that go primarily to urban hospitals.
- The gap between urban and rural hospitals' inpatient margins grew between 1992 and 1998. One factor for this divergence is that urban hospitals had greater success in controlling cost growth, at least partly in response to pressures from managed care. In 2001 and 2002, this difference narrowed somewhat, as payment policies targeted to rural hospitals have been implemented. Policy changes made in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 targeted to rural hospitals should reduce the difference in acute inpatient margins further (see Chart 7-18).

Chart 7-13. Medicare acute inpatient PPS margins, by teaching status, 1991–2002

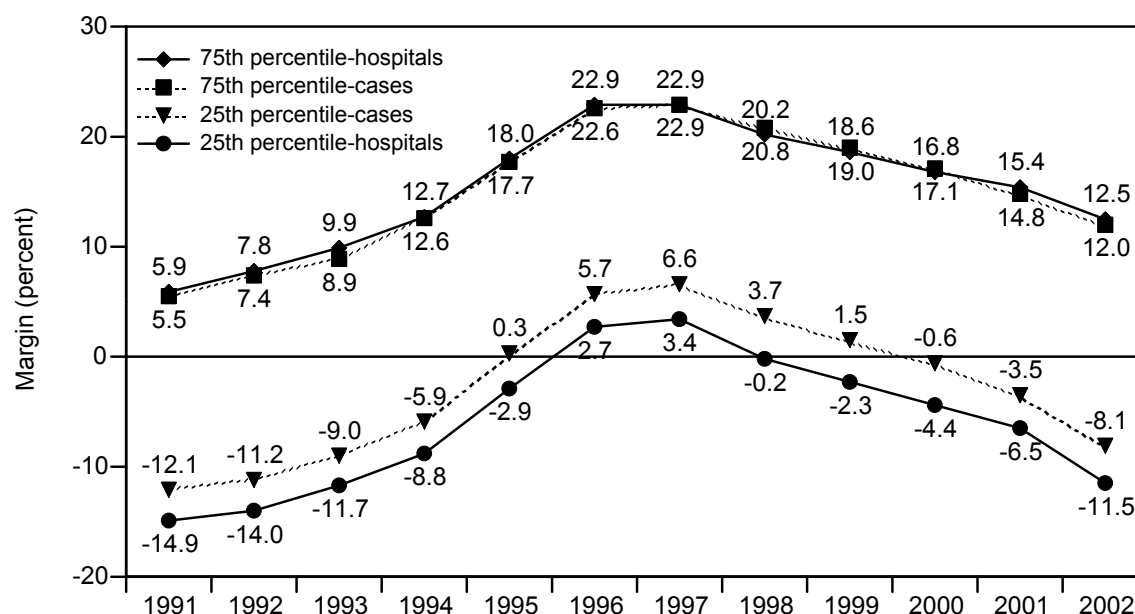


Note: PPS (prospective payment system). Major teaching hospitals are defined by a ratio of interns and residents to beds of 0.25 or greater, while other teaching hospitals have a ratio of less than 0.25. A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and imputed for hospitals for which 2002 costs reports were not available. Analysis excludes critical access hospitals. Medicare acute inpatient margin includes services covered by the acute care inpatient PPS.

Source: MedPAC analysis of Medicare cost report data (third quarter 2003) from CMS.

- Major teaching hospitals have consistently had higher inpatient prospective payment system margins than other teaching hospitals and nonteaching hospitals. Major teaching hospitals' and other teaching hospitals' better financial performance is due largely to the additional payments they receive from the indirect medical education and disproportionate share adjustments.
- In 1991, major teaching hospitals' margins stood at 6.8 percent, compared to -6.4 percent for nonteaching hospitals. Margins rose substantially for all groups through 1997, peaking at 25.8 percent for major teaching hospitals and 12.6 percent for nonteaching hospitals. Since then, inpatient margins have fallen less for major teaching hospitals than for nonteaching hospitals, dropping 8.3 and 13.8 percentage points, respectively, primarily reflecting lower growth in per case costs for major teaching hospitals.

Chart 7-14. Distribution of Medicare acute inpatient PPS margins, 1991–2002

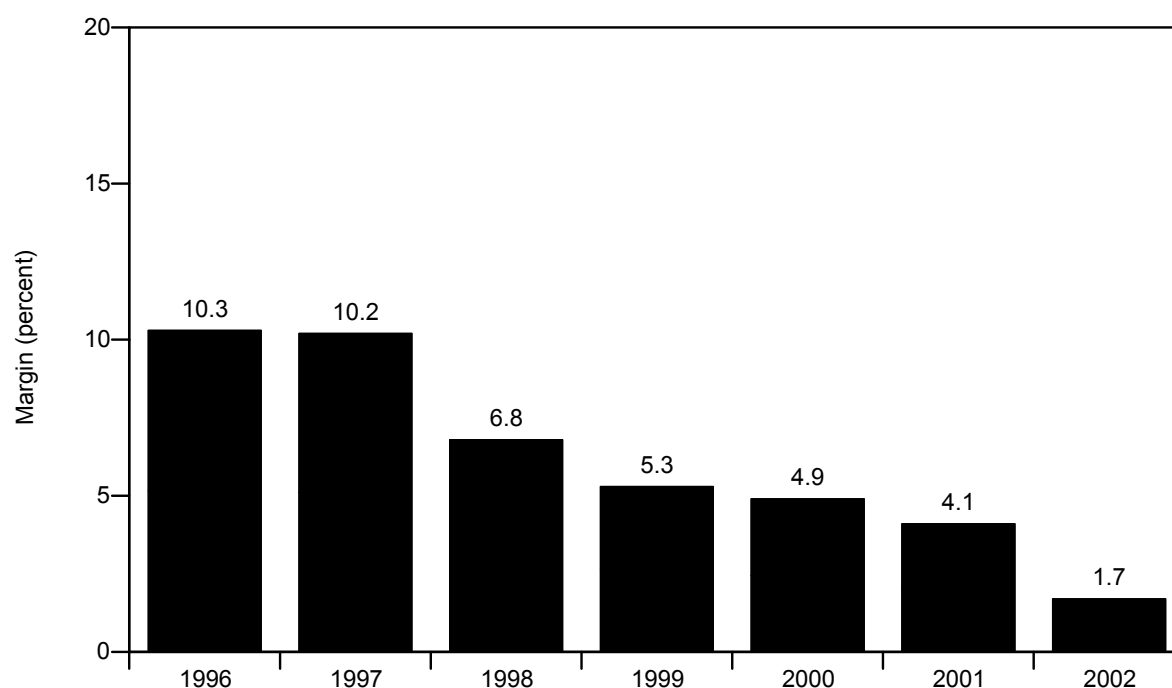


Note: PPS (prospective payment system). A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and imputed for hospitals for which 2002 cost reports were not available. Analysis excludes critical access hospitals. Medicare acute inpatient PPS margin includes services covered by the acute care inpatient PPS. The graph shows two measures of distribution—the 25th and 75th percentiles of margins among hospitals and these percentiles weighted by case load.

Source: MedPAC analysis of Medicare cost report data (third quarter 2003) from CMS.

- Like the aggregate margin, the trend in the distribution of Medicare inpatient margins rose from 1991 to 1997, and then fell through 2002.
- The gap between the 25th and 75th percentile of the Medicare inpatient margin for hospitals narrowed slightly between 1992 and 1997. Since then, however, the gap has widened from 19.5 percentage points to 24 percentage points in 2002.
- In 2002, about 51 percent of hospitals had positive Medicare inpatient margins. These hospitals accounted for 53 percent of Medicare discharges.
- There is not much difference between the hospital and case weighted acute inpatient margin at the 75th percentile. At the 25th percentile, however, the case weighted margin is consistently higher than the hospital based margin, indicating that hospitals in the bottom quarter of acute inpatient margins have a less than proportionate share of cases.

Chart 7-15. Overall Medicare margins, 1996–2002

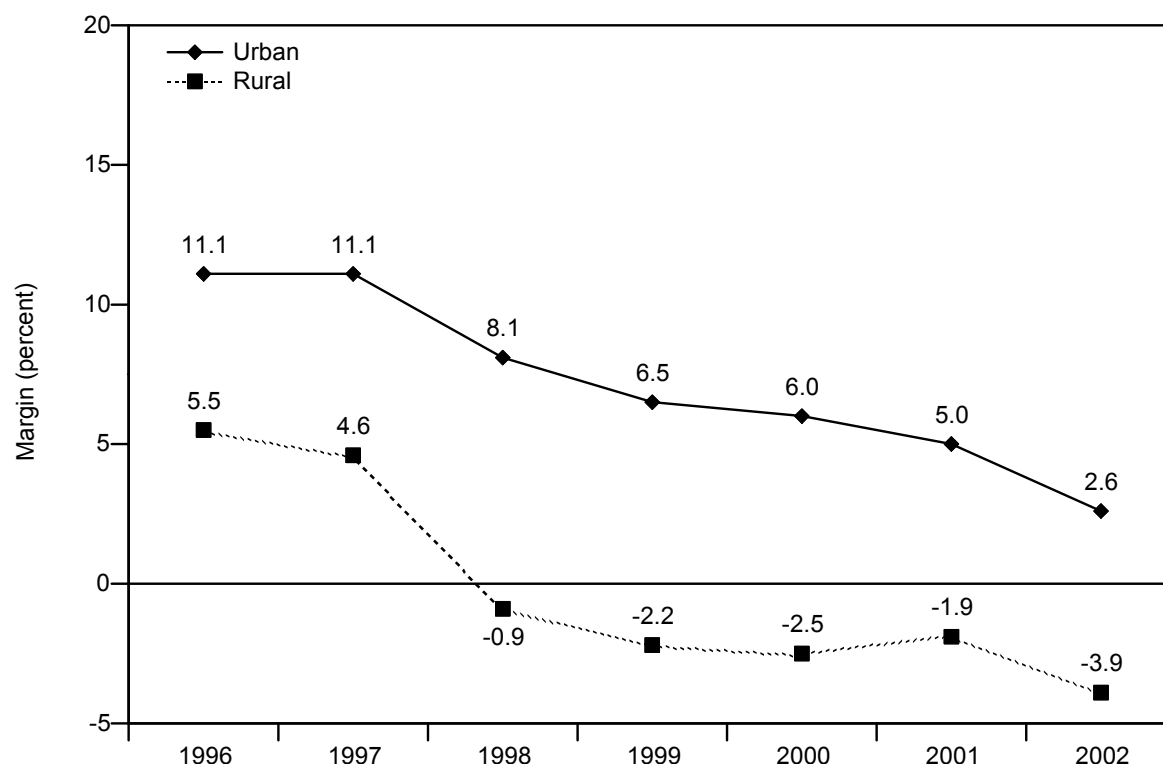


Note: A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and imputed for hospitals for which 2002 cost reports were not available. Analysis excludes critical access hospitals. Overall Medicare margins cover the costs and payments of acute hospital inpatient, outpatient, inpatient psychiatric and rehabilitation units, skilled nursing facilities, and home health services, as well as graduate medical education and bad debts. Data on overall Medicare margins before 1996 are unavailable.

Source: MedPAC analysis of Medicare cost report data (third quarter 2003) from CMS.

- The overall Medicare margin incorporates payments and costs for acute inpatient, outpatient, skilled nursing, home health, and inpatient psychiatric and rehabilitative services, as well as graduate medical education and bad debts. The overall margin is available only since 1996, but it follows a trend similar to that of the inpatient margin.
- The overall margin is lower than the inpatient margin, which is probably biased upward due to incentives to shift costs to cost centers that have been reimbursed based on costs. The overall margin is intended to correct for any cost allocation bias.
- The overall Medicare margin peaked in 1996 at 10.3 percent. In fiscal year 2002, it was 1.7 percent.

Chart 7-16. Overall Medicare margins, by urban and rural location, 1996–2002

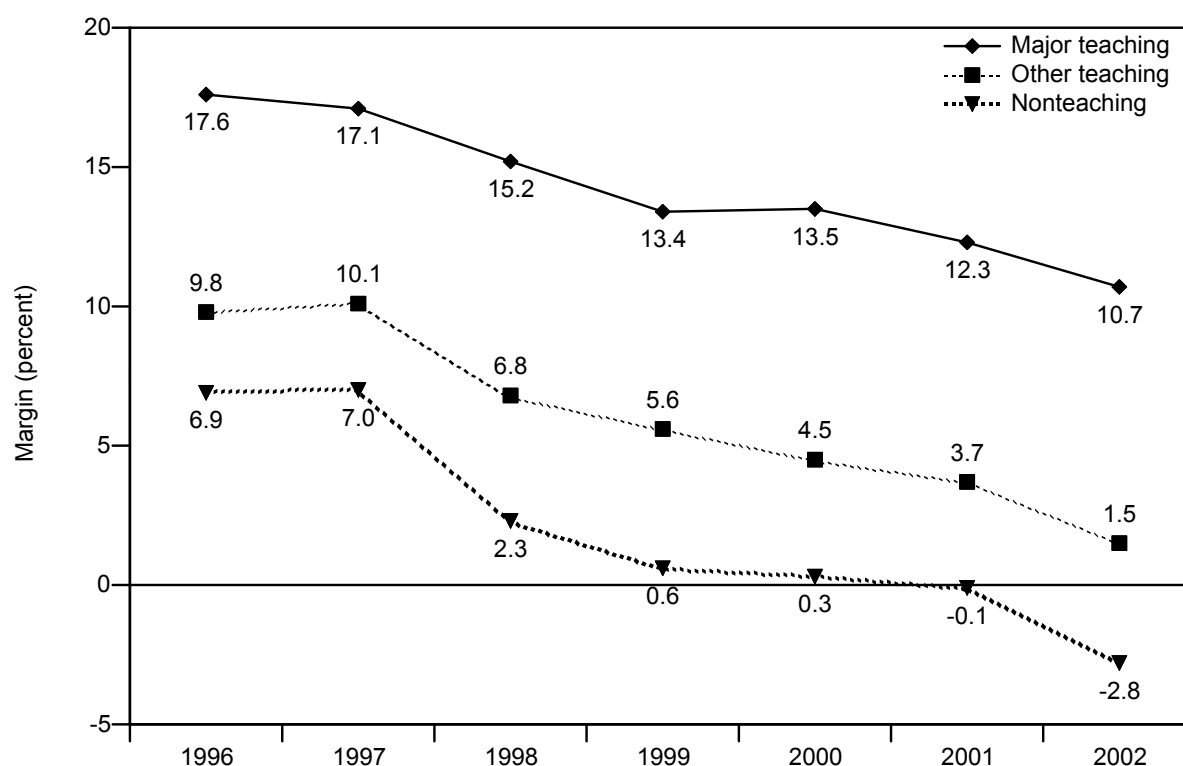


Note: A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and imputed for hospitals for which 2002 cost reports were not available. Analysis excludes critical access hospitals. Overall Medicare margins cover the costs and payments of acute hospital inpatient, outpatient, inpatient psychiatric and rehabilitation units, skilled nursing facilities, and home health services, as well as graduate medical education and bad debts. Data on overall Medicare margins before 1996 are unavailable.

Source: MedPAC analysis of Medicare cost report data (third quarter 2003) from CMS.

- As with inpatient margins, overall Medicare margins have been consistently higher for urban hospitals than for rural hospitals.
- The difference in margins between the two groups grew between 1996 and 1998 but has since narrowed. In 1996, the overall margin for urban hospitals was 11.1 percent, compared with 5.5 percent for rural hospitals. In 2002, the overall margin for urban hospitals was 2.6 percent, compared with -3.9 percent for rural hospitals. Policy changes made in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 targeted to rural hospitals should further narrow the difference in overall Medicare margins between urban and rural hospitals (see Chart 7-18).
- A large part of the difference in financial performance between urban and rural hospitals is attributable to urban hospitals receiving more disproportionate share and indirect medical education payments.

Chart 7-17. Overall Medicare margins, by teaching status, 1996–2002

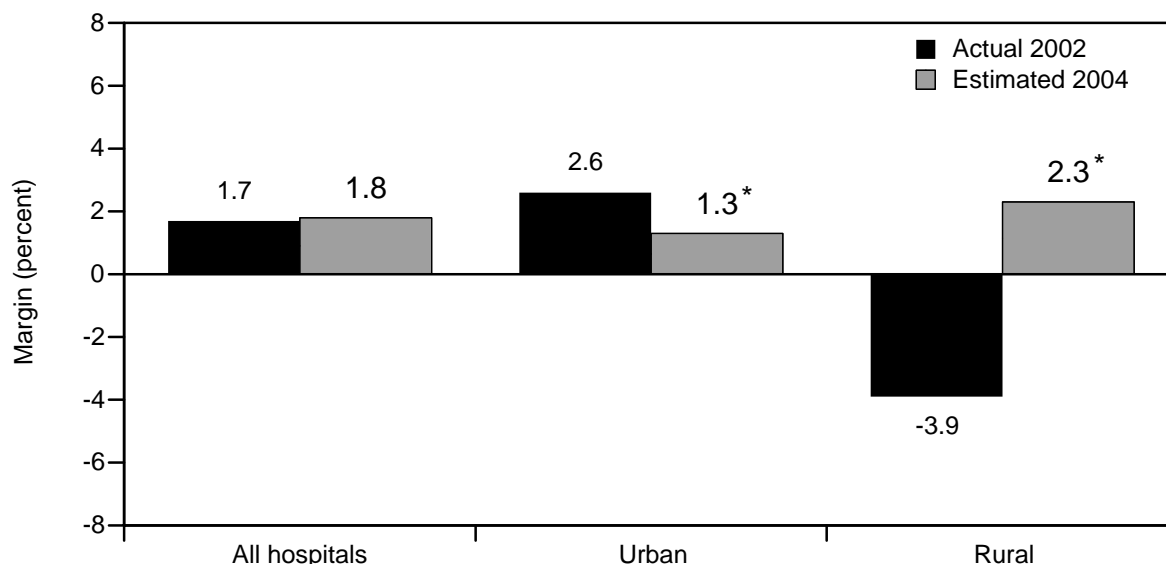


Note: Major teaching hospitals are defined by a ratio of interns and residents to beds of 0.25 or greater, while other teaching hospitals have a ratio of less than 0.25. A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and imputed for hospitals for which 2002 cost reports were not available. Analysis excludes critical access hospitals. Overall Medicare margins cover the costs and payment of acute hospital inpatient, outpatient, inpatient psychiatric and rehabilitation units, skilled nursing facilities, and home health services, as well as graduate medical education and bad debts. Data on overall Medicare margins before 1996 are unavailable.

Source: MedPAC analysis of Medicare cost report data (third quarter 2003) from CMS.

- Major teaching hospitals consistently have had higher overall Medicare margins than other teaching hospitals and nonteaching hospitals primarily because of the additional payments they receive through the indirect medical education and disproportionate share adjustments under the acute inpatient prospective payment system.
- In 2002, overall Medicare margins for major teaching hospitals were 10.7 percent, compared with 1.5 percent for other teaching and –2.8 percent for nonteaching hospitals.
- The difference in overall Medicare margins between major teaching hospitals and nonteaching hospitals has grown from about 10 percentage points in 1997 to 14 percentage points in 2002, reflecting in part the lower cost growth of major teaching hospitals.

Chart 7-18. Overall Medicare margin, actual for 2002 and simulated for 2004 to account for current policy, including MMA provisions



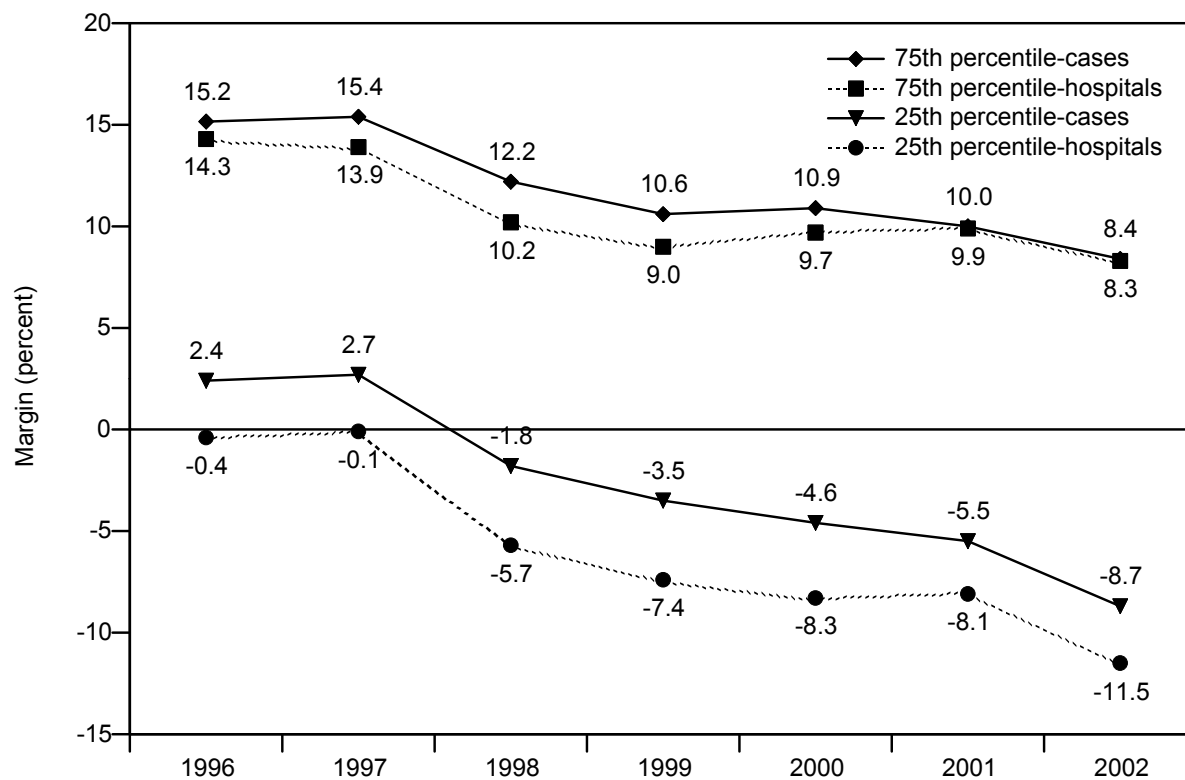
Note: MMA (Medicare Prescription Drug, Improvement, and Modernization Act of 2003). Data for all hospitals covered by Medicare's inpatient PPS (prospective payment system), excluding critical access hospitals (CAHs). Based on Medicare-allowable costs, with imputed values for hospitals whose 2002 cost reports were unavailable. Estimates for 2004 reflect the effects of policy changes implemented between 2002 and 2004 plus policy changes (other than updates) scheduled under the provisions of the MMA to go into effect in 2005.

*Two provisions of the MMA could not be modeled at the hospital-specific level. These are a one-time opportunity for hospitals to appeal their wage indexes and liberalization of payments for CAHs. The estimated 2004 margin for all hospitals reflects a 0.4 percent payment increase for these provisions. While the margins shown for both urban and rural hospitals are understated by this amount, the two provisions are expected to have a greater proportionate impact on rural facilities.

Source: MedPAC analysis of Medicare Cost Report file, MedPAR, and market basket data from CMS.

- The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) includes a number of provisions that will increase both inpatient and outpatient payments to hospitals. These provisions were targeted primarily to rural hospitals; consequently, rural hospital margins rose from -3.9 percent in 2002 to an estimated 2.3 percent in 2004.
- For urban facilities, we estimate that the increase in payments from MMA provisions is offset by CMS's tightening of inpatient outlier payments. In 2002, CMS discovered that certain hospitals were manipulating the outlier system, resulting in systematic overpayment for outlier cases. In June 2003, CMS implemented a revised method with the intent of returning aggregate outlier payments to the target level. In modeling payments for 2004, we assumed CMS's new outlier policy will achieve that goal. However, if outlier payments remain above the intended level, our margin estimate for 2004, all else equal, would be too low.
- A list of the key MMA provisions affecting hospital services can be found in Chapter 3A of MedPAC's March 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/Mar03_Ch3A.pdf. Additional information on the outlier policy issue can be found in the Medicare 2002 Hospital Outlier Payment Policy, available at http://www.medpac.gov/publications/other_reports/outlier%20memo.pdf.

Chart 7-19. Distribution of overall Medicare margins, 1996–2002

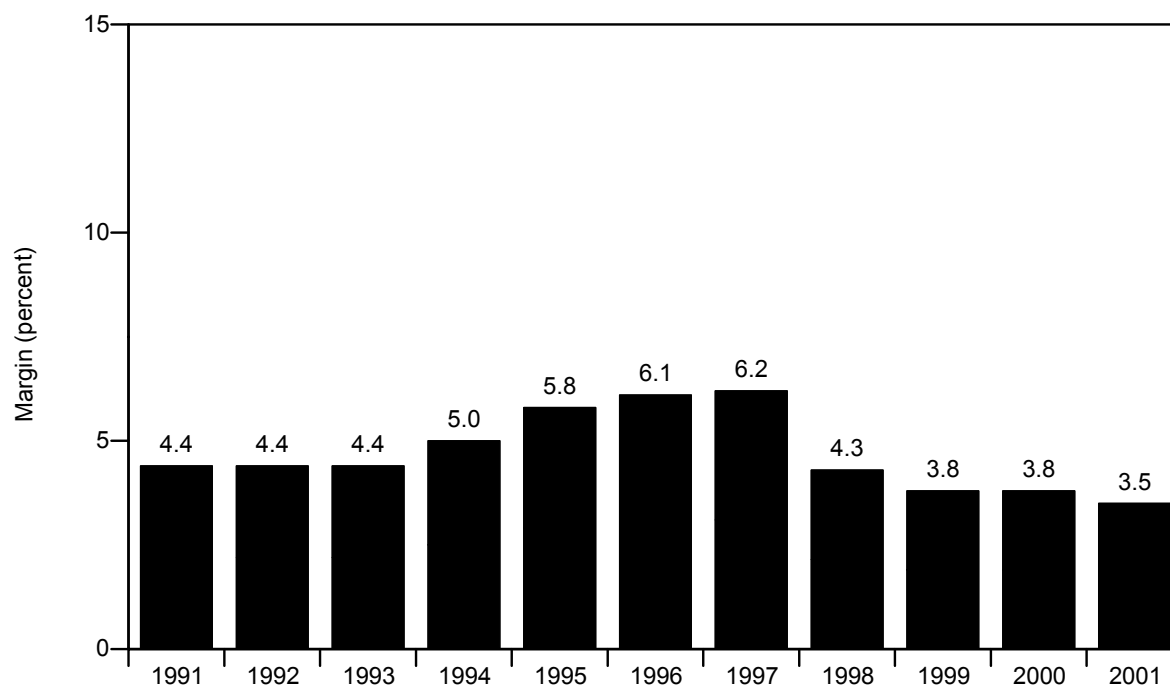


Note: A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and imputed for hospitals for which 2002 cost reports were not available. Analysis excludes critical access hospitals. Overall Medicare margins include the costs and payments of acute hospital inpatient, outpatient, inpatient psychiatric and rehabilitation units, skilled nursing facilities, and home health services, as well as graduate medical education and bad debts. Data on overall Medicare margins before 1996 are unavailable. The graph shows two measures of distribution—the 25th and 75th percentiles of margins among hospitals and these percentiles weighted by case load.

Source: MedPAC analysis of Medicare cost report data (third quarter 2003) from CMS.

- Like the aggregate overall Medicare margin, the 75th and 25th percentiles of this margin fell from historic high levels in 1996 and 1997 to their lowest level since the measure has been available in 2002.
- Since 1996, the 75th percentile values for the overall Medicare margin based on hospitals have fallen 6 percentage points, whereas the 25th percentile values have fallen 11 percentage points. The gap between the 25th and 75th percentile has also grown from 14 percentage points in the 1996 to 1998 period, to 20 percentage points in 2002.
- The distribution of case weighted margins between the 25th and 75th percentiles is not as wide as it is for hospitals. The 25th percentile case weighted margin is higher, indicating that hospitals in the bottom quarter of Medicare overall margins have a less than proportionate share of costs.
- In 2002, 45 percent of hospitals had positive overall Medicare margins. These hospitals accounted for 48 percent of Medicare inpatient discharges.

Chart 7-20. Hospital total margins, 1991–2001

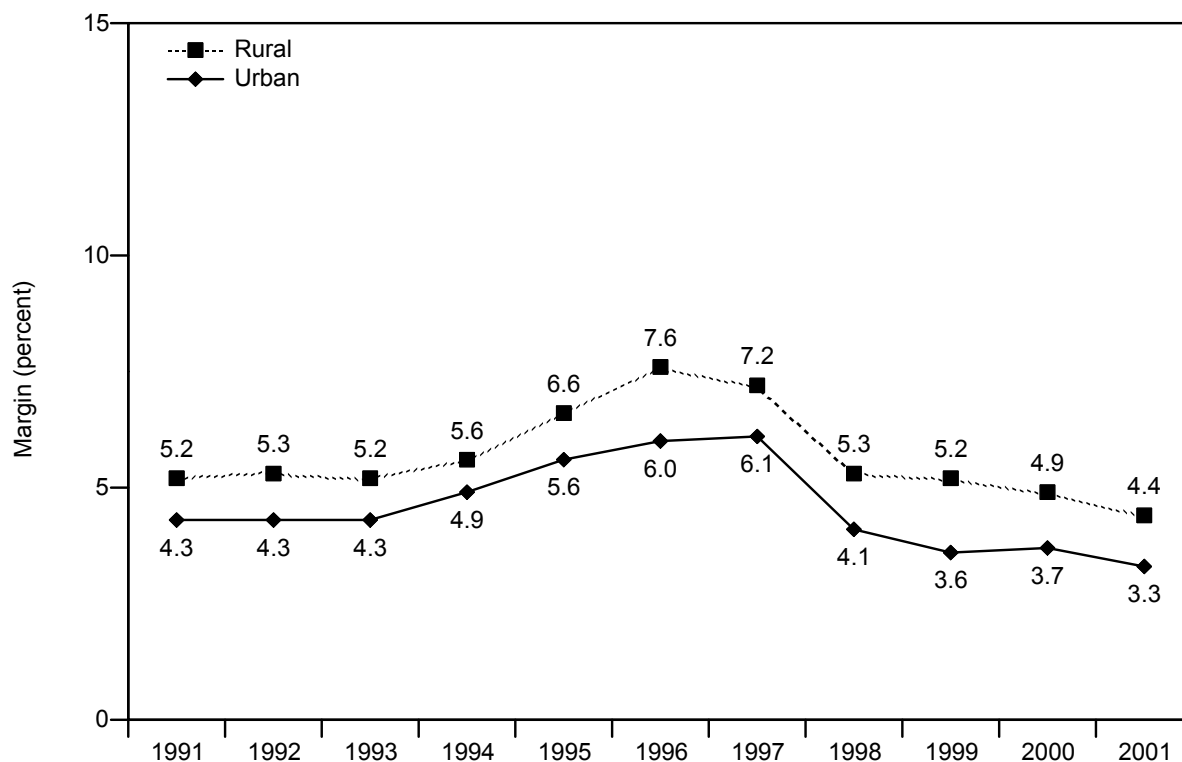


Note: A margin is calculated as revenue minus costs, divided by revenue. Total margin includes all patient care services funded by all payers, plus nonpatient revenue. Analysis excludes critical access hospitals.

Source: MedPAC analysis of Medicare cost report data (third quarter 2003) from CMS.

- The total hospital margin for all payers—Medicare, Medicaid, and private payers—reflects the relationship of all hospital revenues to all hospital costs, including inpatient, outpatient, post-acute, and nonpatient services.
- The total hospital margin gradually climbed from 4.4 percent in the 1991 to 1993 period to 6.2 percent in 1997, before declining to 3.5 percent in 2001.
- The recent fall in total margins corresponds to a drop in both Medicare and private payer margins. Medicare overall margins from 1996 through 2001 were higher than the total margin.
- In 2001, 68 percent of hospitals had positive total margins. These hospitals accounted for 72 percent of Medicare inpatient prospective payment system discharges.

Chart 7-21. Total hospital margins, by urban and rural location, 1991–2001

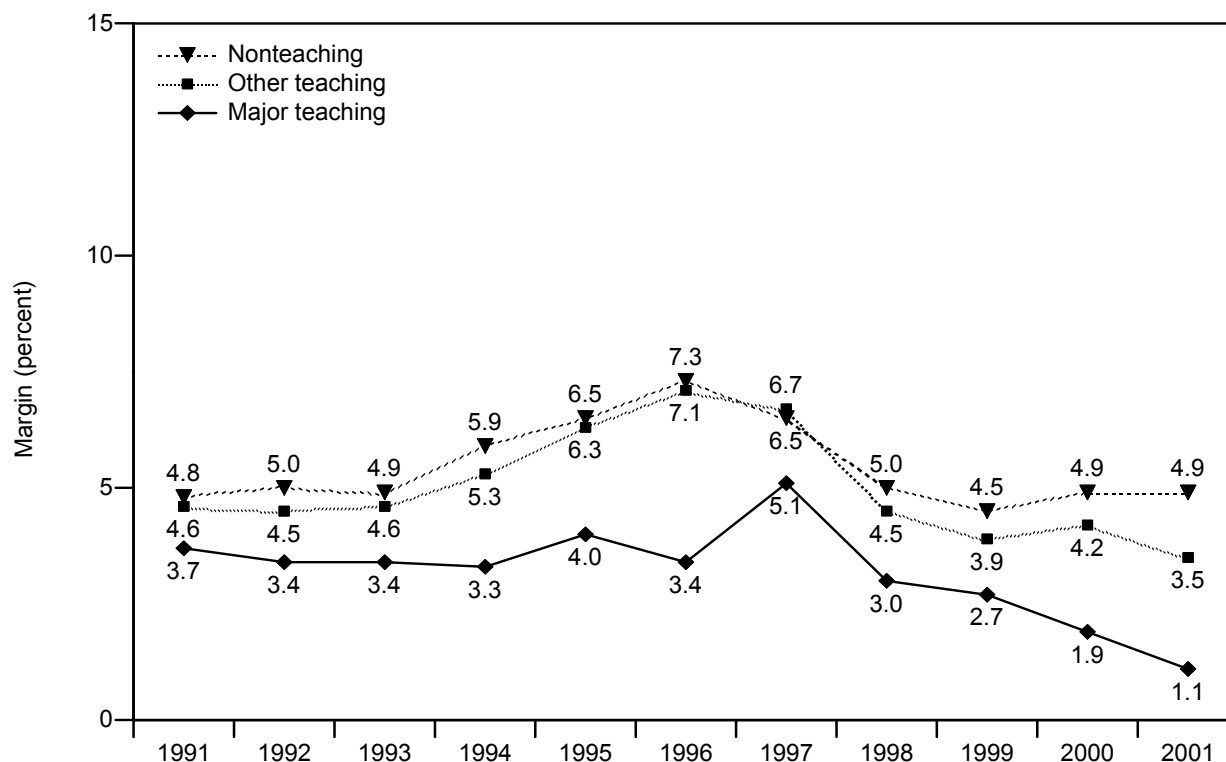


Note: A margin is calculated as revenue minus costs, divided by revenue. Total margin includes all patient care services funded by all payers, plus nonpatient revenue. Analysis excludes critical access hospitals.

Source: MedPAC analysis of Medicare cost report data (third quarter 2003) from CMS.

- Total margins for rural hospitals have consistently been about 1 percentage point higher than total margins for urban hospitals between 1991 and 2001. The general trend in margins is similar for both groups of hospitals.
- In 2001, the aggregate total margin was 3.3 percent for urban hospitals and 4.4 percent for rural hospitals. This relationship may be affected by Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provisions aimed at helping rural hospitals (see Chart 7-18).

Chart 7-22. Total hospital margins, by teaching status, 1991–2001

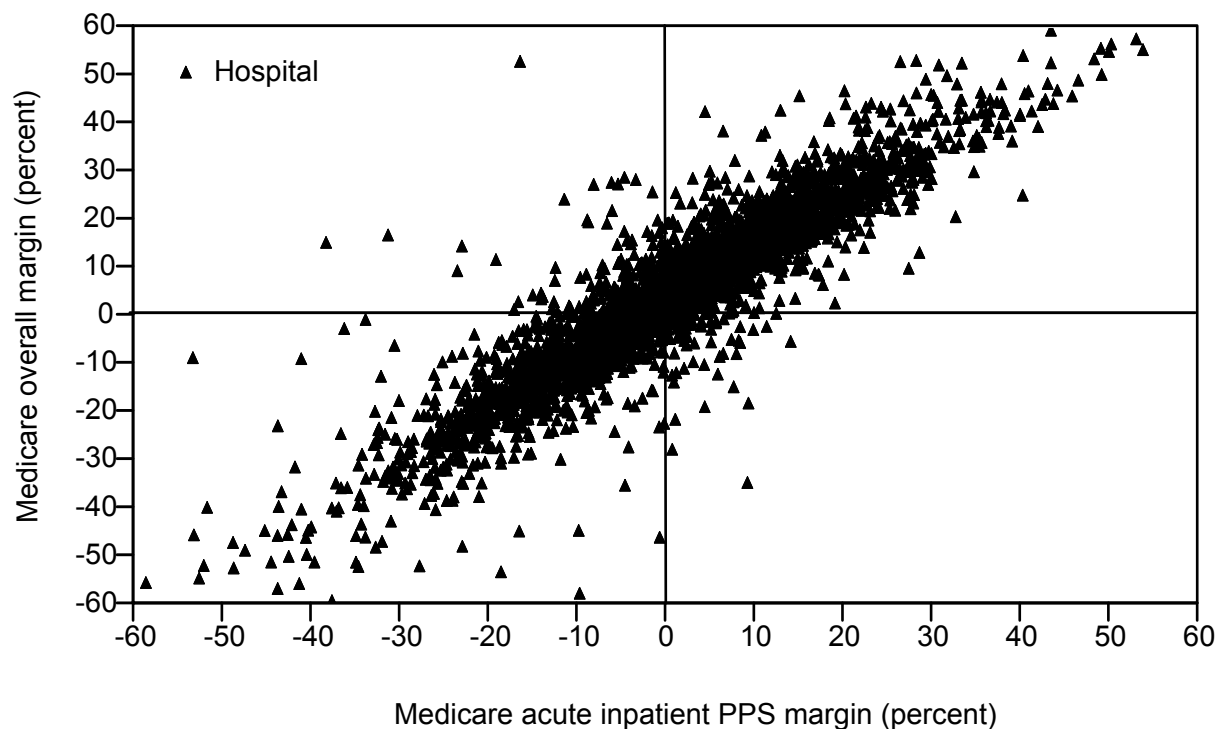


Note: Major teaching hospitals are defined by a ratio of interns and residents to beds of 0.25 or greater, while other teaching hospitals have a ratio of less than 0.25. A margin is calculated as revenue minus costs, divided by revenue. Total margin includes all patient care services funded by all payers, plus nonpatient revenue. Analysis excludes critical access hospitals.

Source: MedPAC analysis of Medicare cost report data (third quarter 2003) from CMS.

- The pattern of total margins by teaching status is the opposite of the pattern for Medicare inpatient and overall margins. The total margins of major teaching hospitals have consistently been lower than those for other teaching and nonteaching hospitals, and the gap has expanded somewhat in the last two years.

Chart 7-23. Relationship of acute inpatient PPS and overall Medicare margins, 2001

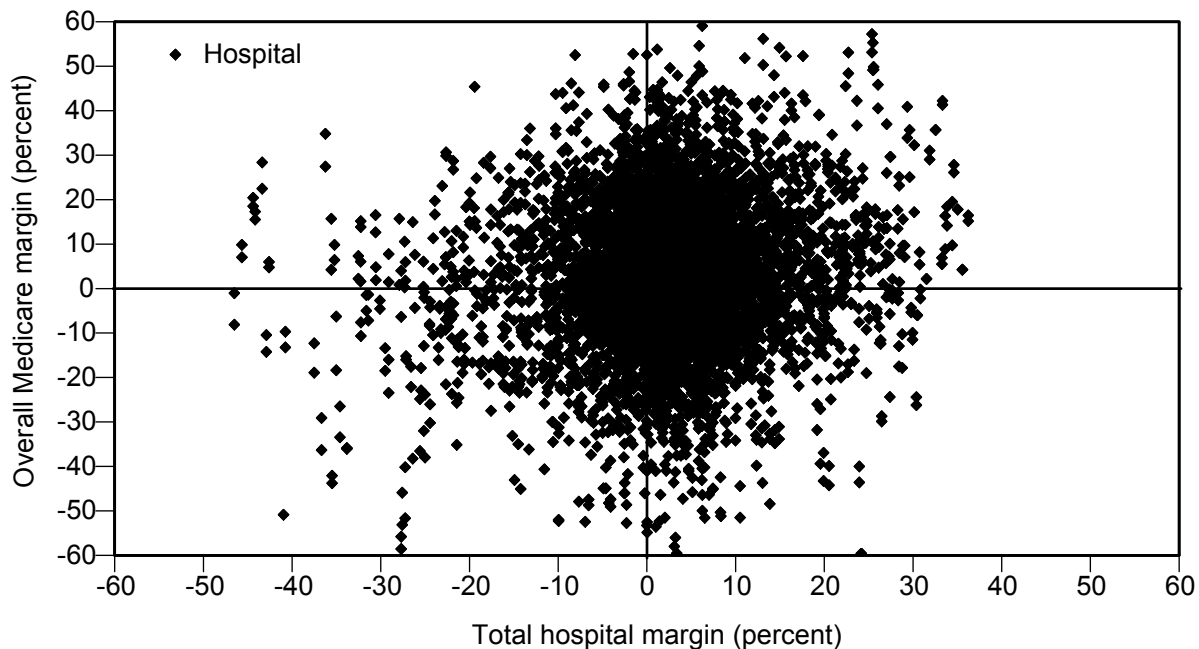


Note: PPS (prospective payment system). A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs. Analysis excludes critical access hospitals. The Medicare acute inpatient PPS margin includes services covered by the acute care inpatient PPS. Overall Medicare margins cover the costs and payments of acute hospital inpatient, outpatient, inpatient psychiatric and rehabilitation units, skilled nursing facilities, and home health services, as well as graduate medical education and bad debts.

Source: MedPAC analysis of Medicare cost report data (third quarter 2003) from CMS.

- The Medicare inpatient and overall margins are strongly correlated ($R^2=0.883$). The Medicare overall and inpatient margins are closely related in part because inpatient payments make up about three-quarters of total Medicare payments.
- The Medicare overall margin tends to be lower than the inpatient margin, which may be overstated due to cost allocation bias.

Chart 7-24. Relationship of overall Medicare and total margins, 2001

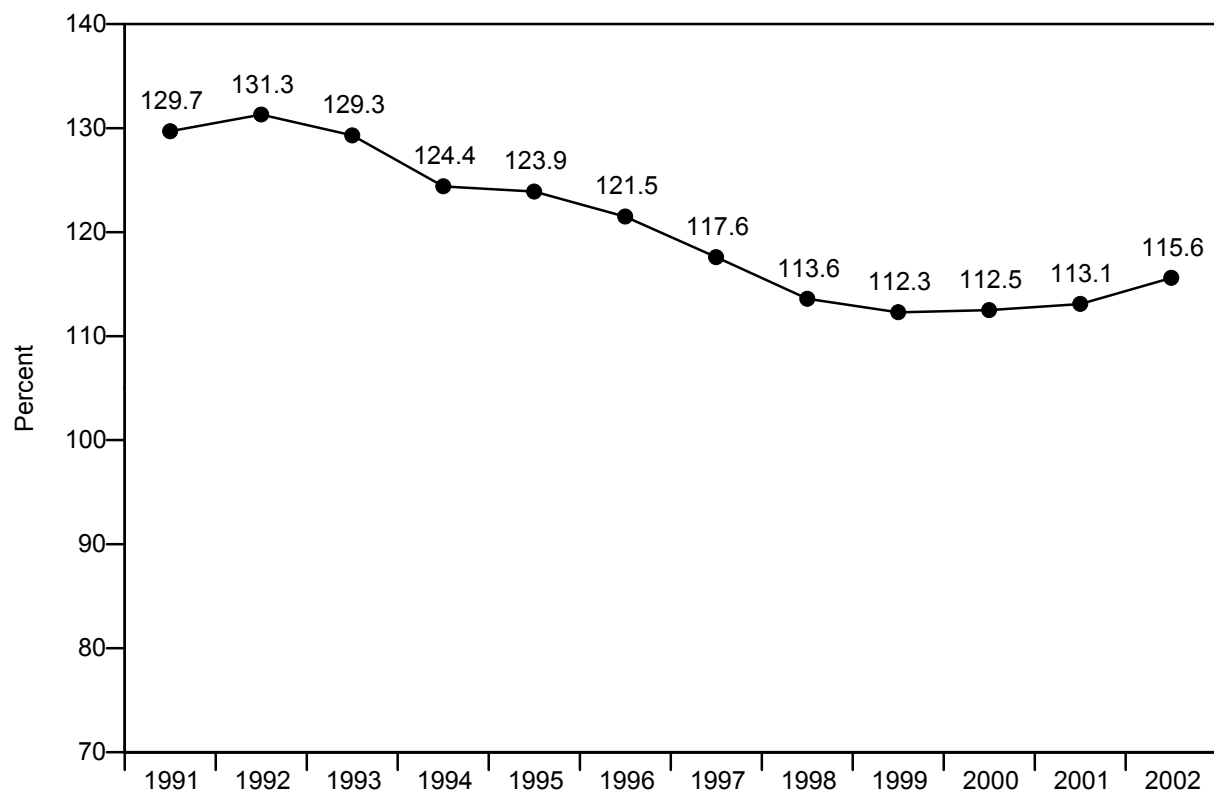


Note: A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and imputed for hospitals for which 2000 cost reports were not available. Analysis excludes critical access hospitals. Overall Medicare margins cover the costs and payments of acute hospital inpatient, outpatient, inpatient psychiatric and rehabilitation units, skilled nursing facility, and home health services, as well as graduate medical education and bad debts. Total margin includes all patient care services funded by all payers, plus nonpatient revenues.

Source: MedPAC analysis of Medicare cost report data (third quarter 2003) from CMS.

- There is virtually no relationship between hospitals' overall Medicare margins and total (all payer) margins ($R^2=0.02$). That is, hospitals' performance in Medicare is not a good predictor of their performance across all payers and vice versa.
- Hospitals with negative Medicare margins and those with positive Medicare margins were almost equally likely to have positive total margins: 66 percent of hospitals with negative overall Medicare margins had positive total margins, while 73 percent of hospitals with positive Medicare margins had positive total margins.
- Hospitals in the upper right quadrant of the graph (38 percent), had positive overall Medicare margins and positive total margins in 2001, whereas hospitals in the lower left quadrant (16 percent) had negative overall Medicare margins and negative total margins.

Chart 7-25. Hospital payment-to-cost ratios for private payers, 1991–2002

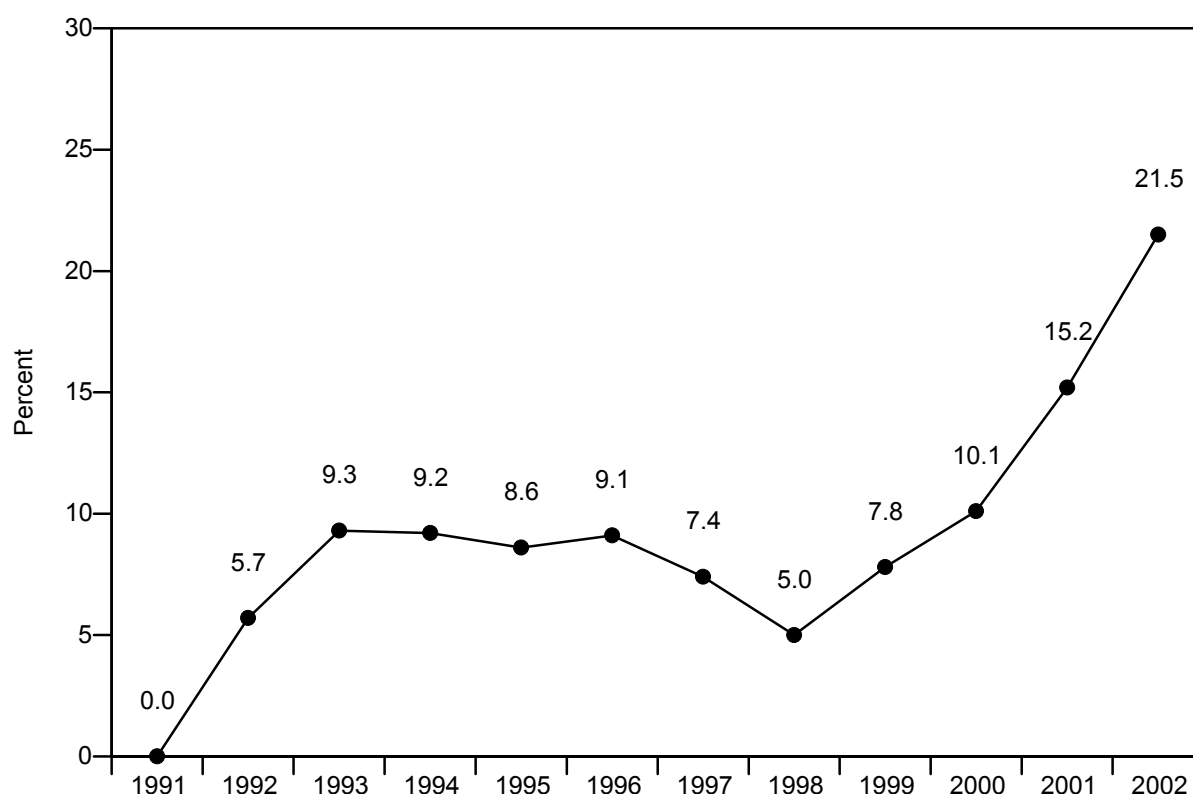


Note: Payment-to-cost ratios indicate the relative degree to which payments from each payer cover the costs of treating that payer's patients. Data are for community hospitals and cover all hospital services. Imputed values were used for missing data (about 33 percent of observations). Most Medicare and Medicaid managed care patients are included in the private payers category.

Source: MedPAC analysis of data from the American Hospital Association annual survey of hospitals.

- The decline in private payer payments relative to costs during the 1990s may reflect the pressures on hospitals' revenue exerted by managed care organizations and other private payers through their contractual negotiations. In recent years, it appears that hospitals have been able to increase payments from private payers.

Chart 7-26. Cumulative change in hospital cost per adjusted admission, 1991–2002

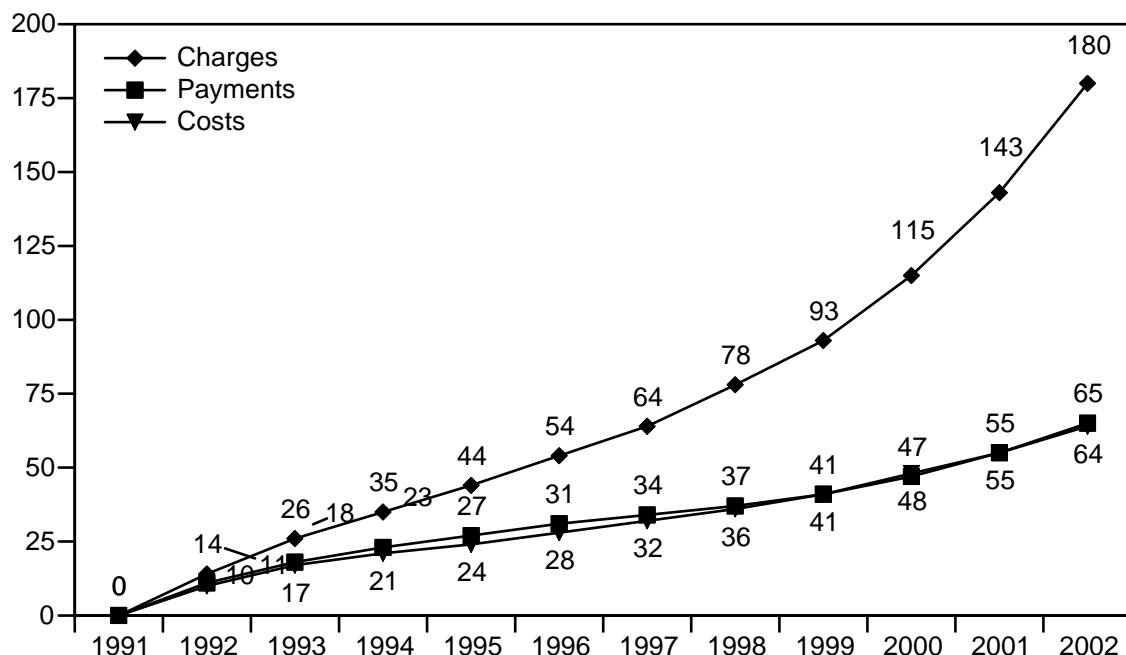


Note: Data are for patients at approximately 5,000 community hospitals.

Source: MedPAC analysis of data from the American Hospital Association annual survey of hospitals.

- Cost per adjusted admission is a comprehensive measure reflecting all patient care services. Adjusted admissions, a measure of hospital volume of inpatient, outpatient, and post-acute services, equals hospital admissions multiplied by the ratio of the sum of inpatient and outpatient revenue to inpatient revenue.
- The annual increase in hospital costs per adjusted admission averaged 4.6 percent from 1991 to 1993. Costs were nearly flat over the next three years and then actually declined in 1997 and 1998, before rising again from 1999 through 2002.
- The steep decline in cost growth may be associated with private sector pressure and decline in length of stay.
- Cost per adjusted admission increased 5.4 percent from \$6,980 in 2001 to \$7,355 in 2002.

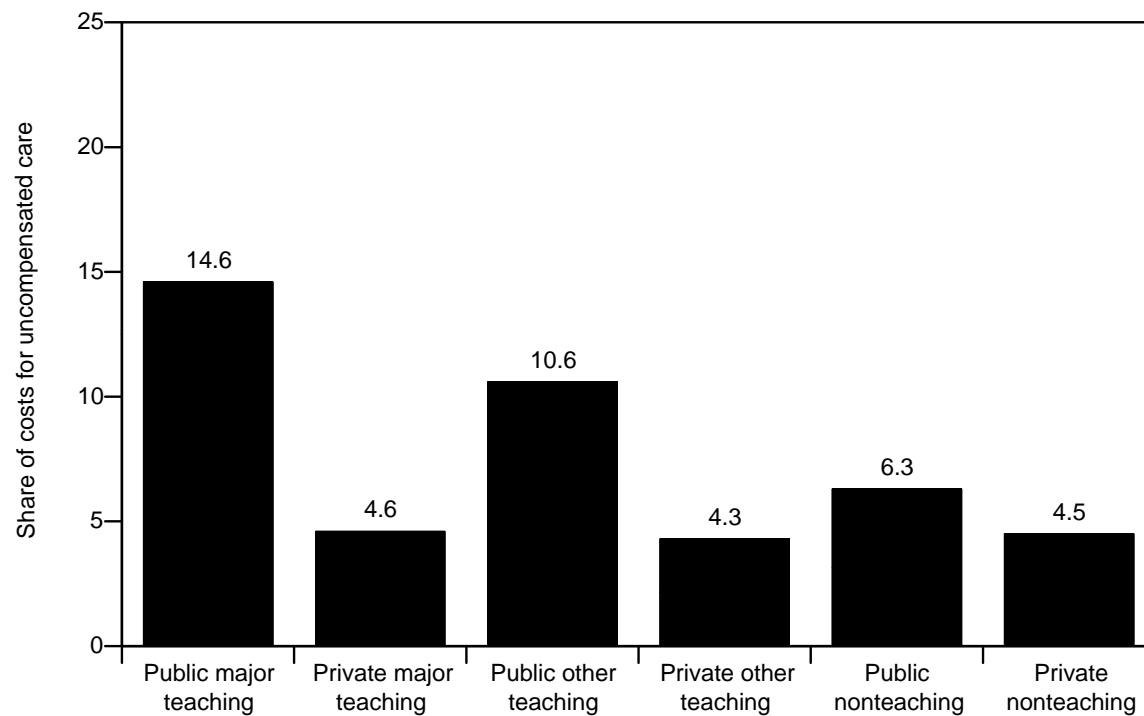
Chart 7-27. Cumulative change in charges, payments, and costs for all hospital patient care services, 1991–2002



Source: MedPAC analysis of data from the American Hospital Association annual survey of hospitals.

- From 1991 through 2002, hospitals' patient care costs and payments (covering all services and all payers) both rose about 65 percent, but hospitals raised their charges by 180 percent—more than two and half times as much. In 2000 through 2002, the difference in rate of growth between what hospitals charge for services and the cost of producing them—around 6 percentage points each year—was the largest in the last decade.
- Since few patients pay full charges, hospitals increasing their charges more than their costs or payments may not have had much impact on their financial performance in the aggregate. Some are concerned, however, that uninsured individuals may be asked to pay full charges and may have collection proceedings applied against them. Faster growth rates for charges in recent years may have resulted from hospitals attempting to maximize revenue from private payers (who often structure their payments as a discount off charges) or their revenue from Medicare outlier payments.
- Additional information on this outlier payment issue can be found in the Medicare 2002 Hospital Outlier Payment Policy, available at http://www.medpac.gov/publications/other_reports/outlier%20memo.pdf.

Chart 7-28. Uncompensated care costs as a percent of total hospital costs, by teaching status and type of control, 2002

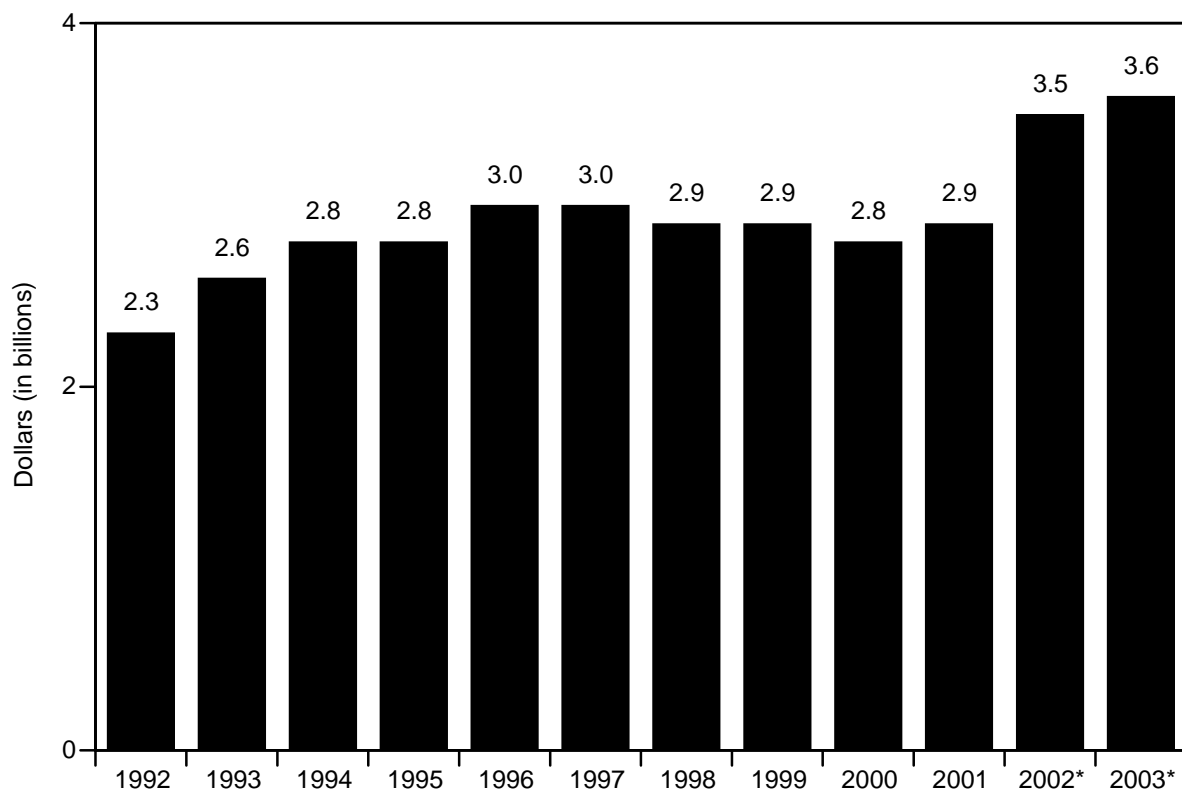


Note: Uncompensated care includes charity care, which is furnished without expectation of payment, and bad debts, for which the provider has made an unsuccessful effort to collect payment due.

Source: American Hospital Association annual survey of hospitals.

- Among major teaching hospitals, public institutions devote almost 15 percent of their resources to providing uncompensated care, compared to about 5 percent for private (nonprofit or proprietary) facilities. Although the differences are smaller, public other teaching and nonteaching institutions also provide more uncompensated care than their private counterparts.

Chart 7-29. Medicare payments to inpatient psychiatric facilities, 1992–2001



Note: *Estimated spending. CMS estimates the prospective payment system for these facilities will be implemented in 2005.

Source: CMS, Office of the Actuary.

- Medicare program spending for beneficiaries' care in inpatient psychiatric facilities increased 3 percent per year on average, from \$2.3 billion in 1992 to \$2.9 billion in 2001. CMS estimates that program spending will increase 11 percent per year for 2002 and 2003 to \$3.6 billion.
- Spending on inpatient psychiatric facilities makes up about 1 percent of Medicare's total spending.
- In 2004, there are 1,867 inpatient psychiatric facilities—478 freestanding and 1,389 hospital-based units.

Chart 7-30. Inpatient psychiatric facilities, 1994–2004

	1994	1996	1998	2000	2002	2004
Freestanding hospitals	702	642	627	582	503	478
Hospital-based units	1,346	1,445	1,489	1,487	1,437	1,389
Total	2,048	2,087	2,116	2,069	1,940	1,867

Source: Online Survey, Certification, and Reporting system from CMS.

- Inpatient psychiatric facilities—both freestanding hospitals and hospital-based units—provide acute hospital care to beneficiaries with mental illnesses or alcohol- and drug-related problems.
- From 1994 to 2004, the number of Medicare-certified freestanding hospitals decreased by 32 percent while the number of hospital-based units increased by 3 percent, with a net loss of 8 percent of psychiatric facilities.
- The proposed inpatient psychiatric facility prospective payment system (PPS) can be found on the CMS website, available at <http://www.cms.hhs.gov/providers/ipfpps/>.
- MedPAC's comments on the proposed PPS can be found at http://www.medpac.gov/publications/other_reports/012704_psych_SK_comment.pdf.

Web links. Acute inpatient service

Short-term hospitals

- Appendix D of the MedPAC March 2003 Report to the Congress provides additional detailed information on hospital margins.

http://www.medpac.gov/publications/congressional_reports/Mar03_AppD.pdf

- Chapter 2A of the MedPAC March 2002 Report to the Congress provides information on the hospital market basket.

http://www.medpac.gov/publications/congressional_reports/Mar02_Ch2A.pdf

- CMS also provides information on the hospital market basket.

<http://www.cms.gov/statistics/health-indicators/t10.asp>

- CMS published the acute inpatient PPS proposed rule in the May 18, 2004 Federal Register.

<http://www.gpoaccess.gov/index.html>

Specialty psychiatric facilities

- CMS provides information on the proposed inpatient prospective payment system.

<http://cms.hhs.gov/providers/ipfpps>

SECTION

8

Ambulatory care

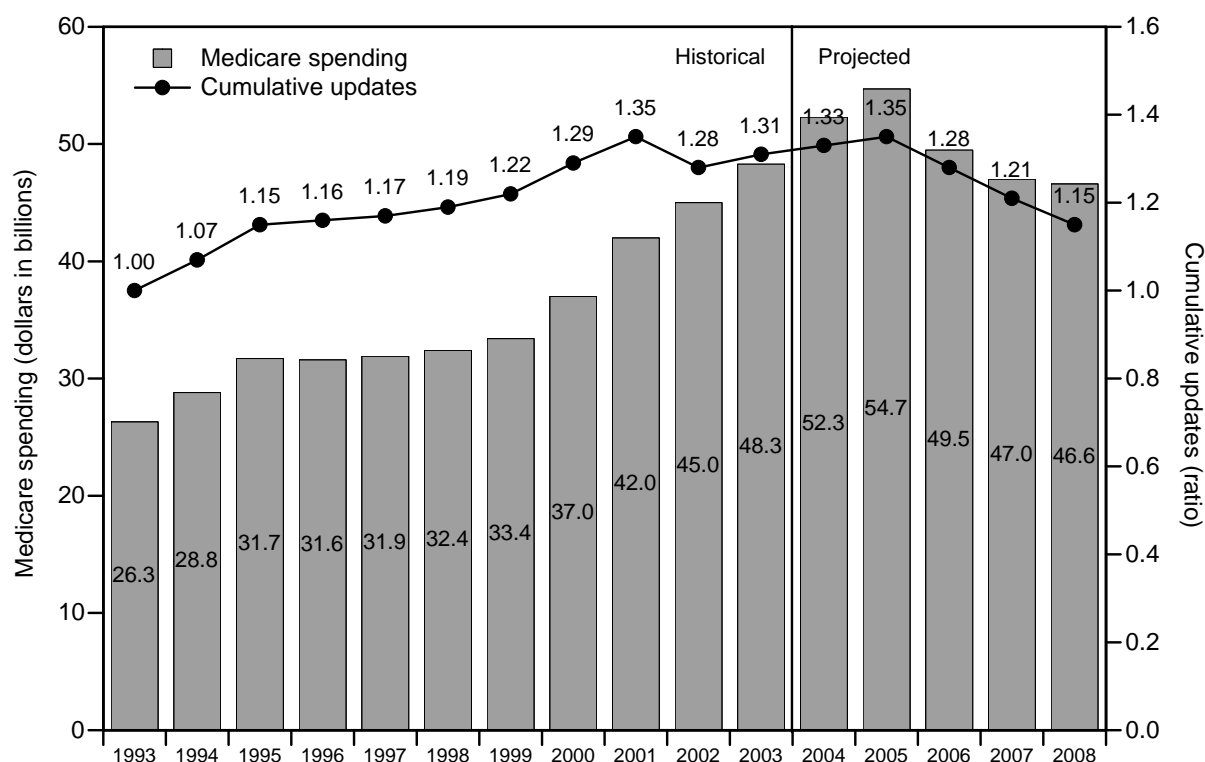
Physicians

Hospital outpatient services

Ambulatory surgical centers

**Independent diagnostic and
testing facility services**

Chart 8-1. FFS Medicare spending and payment updates for physician services, 1993–2008

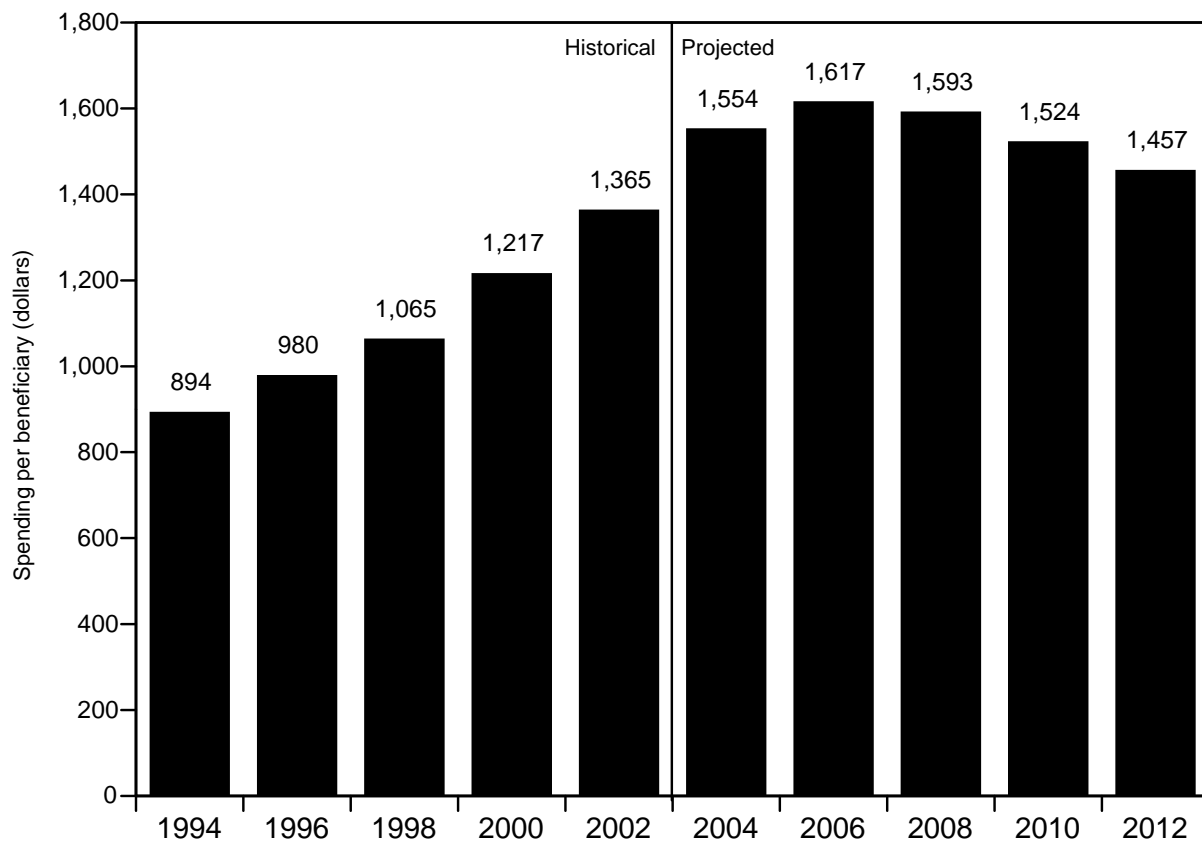


Note: FFS (fee-for-service). Dollars are Medicare spending only, and do not include beneficiary coinsurance.

Source: MedPAC analysis of the 2004 annual report of the Boards of Trustees of the Medicare trust funds.

- Between 1993 and 1999, Medicare spending on physician services was relatively flat. More rapid growth occurred between 1999 and 2003—averaging 9.7 percent annually.
- The sustainable growth rate system (SGR) requires that future payment increases for physician services be adjusted for past actual physician spending relative to a target spending level. To avoid reductions in 2004 and 2005 physician fee schedule rates due to the SGR, the Medicare Modernization Act established minimum payment updates for physician services of 1.5 percent for 2004 and 2005. Under current law, payments for physician services are slated to decline about 5 percent for 7 consecutive years, beginning in 2006.
- Congressional testimony by the Chairman of MedPAC on physician payments and the SGR is available at http://www.medpac.gov/publications/congressional_testimony/050504_SGRTestimony_EC.pdf.
- A full copy of the Trustees report is available at <http://cms.hhs.gov/publications/trusteesreport/default.asp>.

Chart 8-2. Medicare spending per FFS beneficiary on physician services, 1994–2012



Note: FFS (fee-for-service). Dollars are Medicare spending only, and do not include beneficiary coinsurance.

Source: MedPAC analysis of the 2004 annual report of the Boards of Trustees of the Medicare trust funds.

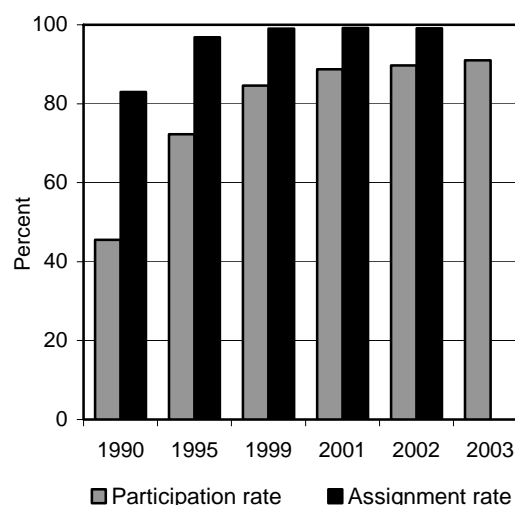
- Fee-for-service (FFS) physician spending per beneficiary has increased annually since 1994 and is expected to continue increasing through 2006.
- Under current law, FFS Medicare payments for physician services per beneficiary are projected to decline after 2006 because of scheduled negative payment updates. The volume of physician services per beneficiary, however, is expected to continue to grow.
- A full copy of the Trustees report is available at <http://cms.hhs.gov/publications/trusteesreport/default.asp>.
- Additional information on Medicare payment for physician services can be found in Chapter 3B of the MedPAC March 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3B.pdf.

Chart 8-3. The supply of physicians furnishing services to beneficiaries has increased

Year	Number of physicians	Part B enrollment (millions)	Number of physicians per 1,000 beneficiaries
1995	460,700	35.641	12.9
1996	469,915	36.104	13.0
1997	476,164	36.445	13.1
1998	478,123	36.756	13.0
1999	484,576	37.022	13.1
2000	489,067	37.315	13.1
2001	494,718	37.657	13.1
2002	506,594	37.946	13.4

Note: FFS (fee-for-service). The numerator of the ratio of physicians per 1,000 beneficiaries includes allopathic and osteopathic physicians and excludes nurse practitioners, physician assistants, psychologists, and other health care professionals. The denominator is the number of beneficiaries enrolled in Medicare Part B, including FFS Medicare and Medicare+Choice, on the assumption that physicians are providing services to both types of beneficiaries.

Source: MedPAC analysis of unpublished CMS data.

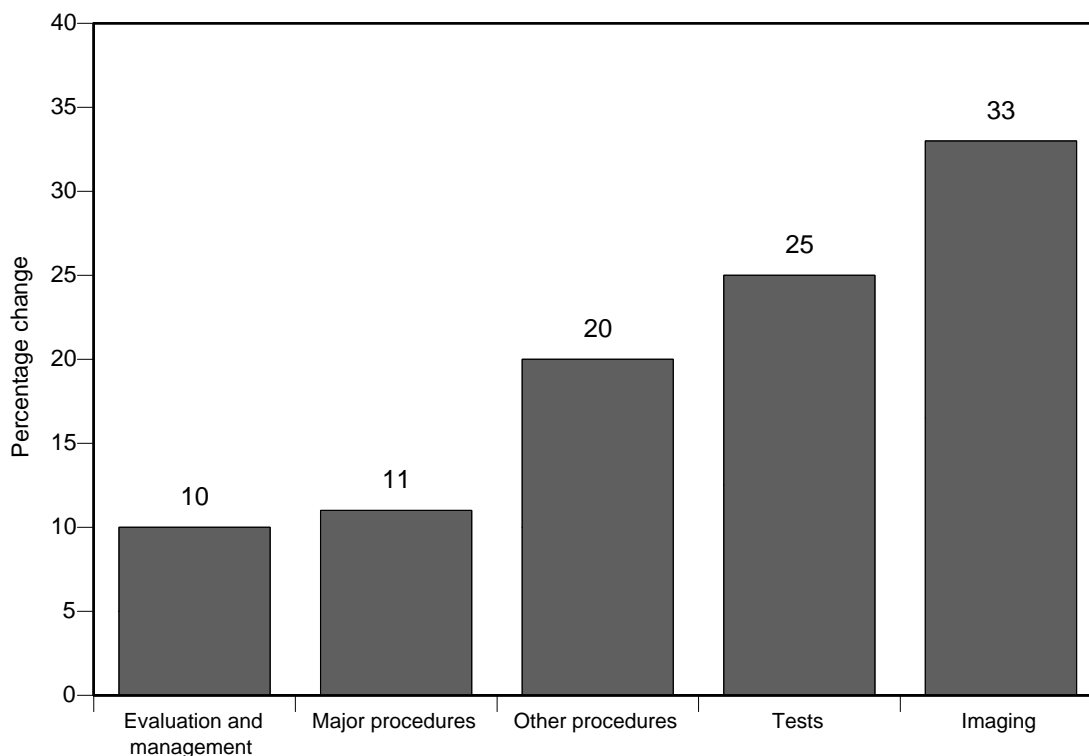


Note: Participation rate is the percent of physicians signing Medicare participation agreements. Assignment rate is the percent of allowed charges paid on assignment. The assignment rate for 2003 is not shown; it requires calculations from claims not yet available.

Source: Ways and Means Greenbook (2000), unpublished CMS data, and MedPAC analysis of 2002 claims for a 5 percent random sample of Medicare beneficiaries.

- The number of physicians billing beneficiaries has more than kept pace with growth in the number of beneficiaries. From 1995 to 2002, the number of physicians billing fee-for-service Medicare grew by 10 percent, but Medicare Part B enrollment grew by 6.5 percent. This difference in growth rates led to an increase in the number of physicians per 1,000 beneficiaries, from 12.9 to 13.4. Note, however, that the number of beneficiaries in physicians' patient caseloads may vary considerably.
- A 2003 General Accounting Office report stated that between 1991 and 2001 the number of physicians in the U.S. increased by 26 percent—twice the rate of total population growth.
- The participation rate—the percentage of physicians who can bill Medicare and who agree to accept assignment on all claims for payment during a year—has risen steadily to 91 percent in 2003.
- When physicians accept assignment, they accept Medicare's fee schedule amount as the service's full charge (of which 20 percent is beneficiary coinsurance). In 2002, 99 percent of allowed charges for physician services were assigned.
- Additional information and analysis related to this topic can be found in Chapter 3B of the MedPAC March 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3B.pdf.

Chart 8-4. Cumulative growth in volume per beneficiary, by type of service, 1999–2002



Source: MedPAC analysis of claims data for 100 percent of beneficiaries.

- Physician services can be classified by type of service. Evaluation and management services consist primarily of office visits but also include consultations and visits to patients in facility settings. Examples of procedures include open heart surgery, replacement of joints, and back surgery. Other procedures include colonoscopy, arthroscopy of the knee, and various eye procedures, such as cataract surgery. Tests range from analysis of specimens in a laboratory to electrocardiograms and cardiovascular stress tests. Imaging includes x-rays of the chest, the musculoskeletal system, and other parts of the body as well as more advanced procedures, such as computed tomography and MRI.
- Growth in the volume of physician services varies by type of service. From 1990 to 2002, volume growth was highest for imaging.
- It is unclear why volume is growing faster for some services than for others. Part of the explanation may relate to the nature of the services. The services with the highest growth rates tend to be more discretionary than other services. Some of the rapid growth could represent diffusion of technology, consumer demand, or practice patterns.
- Further analysis and information can be found in Chapter 4 of the MedPAC June 2003 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/June03_Ch4.pdf.

Chart 8-5. Medicare Economic Index input categories, weights, and projected price changes for 2005

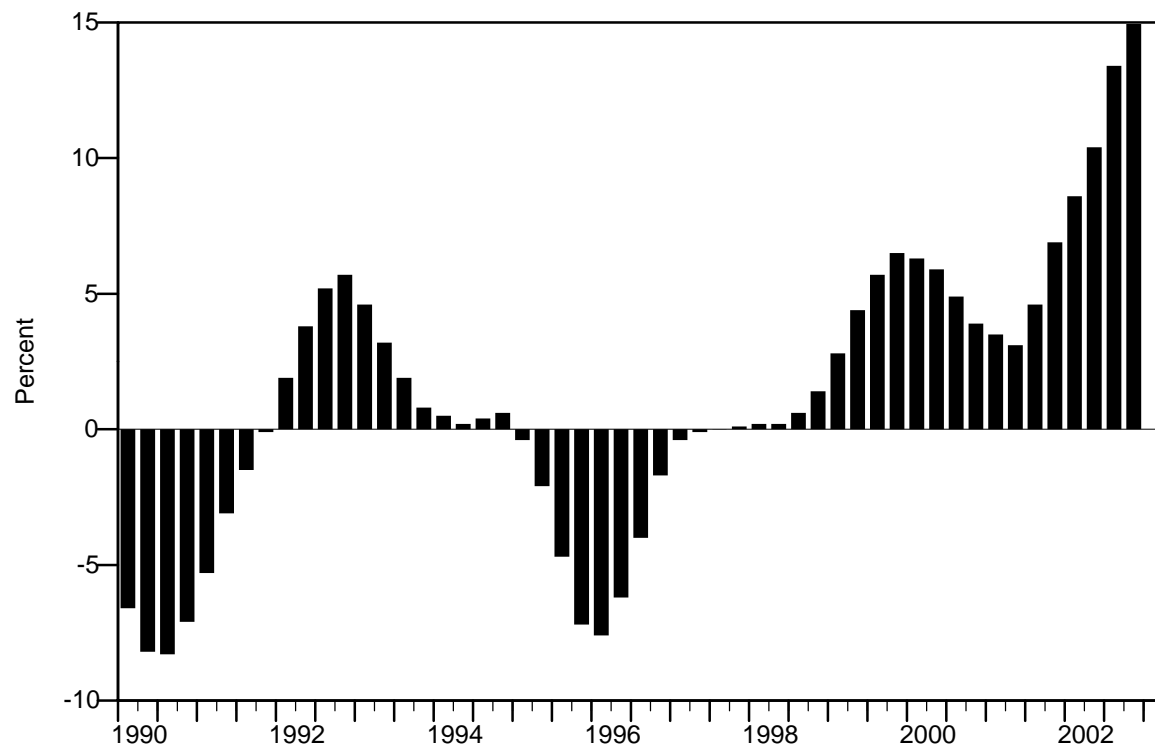
Input component	Category weight (percent)	Price changes for 2005 (percent)
Total	100.0%	3.3%
Physician work	52.5	3.2
Wages and salaries	42.7	3.1
Nonwage compensation	9.7	3.9
Practice expense	47.5	3.3
Nonphysician employee compensation	18.7	3.3
Wages and salaries	13.8	3.1
Nonwage compensation	4.8	4.1
Office expense	12.2	1.8
Professional liability insurance	3.9	8.9
Medical equipment	2.1	1.9
Drugs and supplies	4.3	2.5
Pharmaceuticals	2.3	2.9
Medical materials and supplies	2.0	1.9
Other professional expense	6.4	2.2

Note: Forecasted price changes for individual components are calculated by multiplying the component's weight by its price proxy. Forecasted price changes are not adjusted for productivity. Totals may not sum to 100 due to rounding.

Source: Unpublished fourth-quarter 2005 estimates from CMS dated February 27, 2004.

- An important factor in determining the payment update for physician services is the projected change in input prices for physician services as measured by the Medicare Economic Index (MEI). The MEI is a weighted average of price changes for physician time and effort (i.e., work) and practice expense.
- CMS projects that input prices for physician work will increase 3.2 percent in 2005, based on increases of 3.1 percent in wages and salaries and 3.9 percent in nonwage compensation. Practice expenses are projected to increase 3.3 percent. This projection primarily reflects a 3.3 percent increase in nonphysician employee compensation and a 1.8 percent increase in office expenses.
- Professional liability insurance has the largest projected price change, 8.9 percent.
- Additional information and analysis related to this topic can be found in Chapter 3B of the MedPAC March 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3B.pdf.

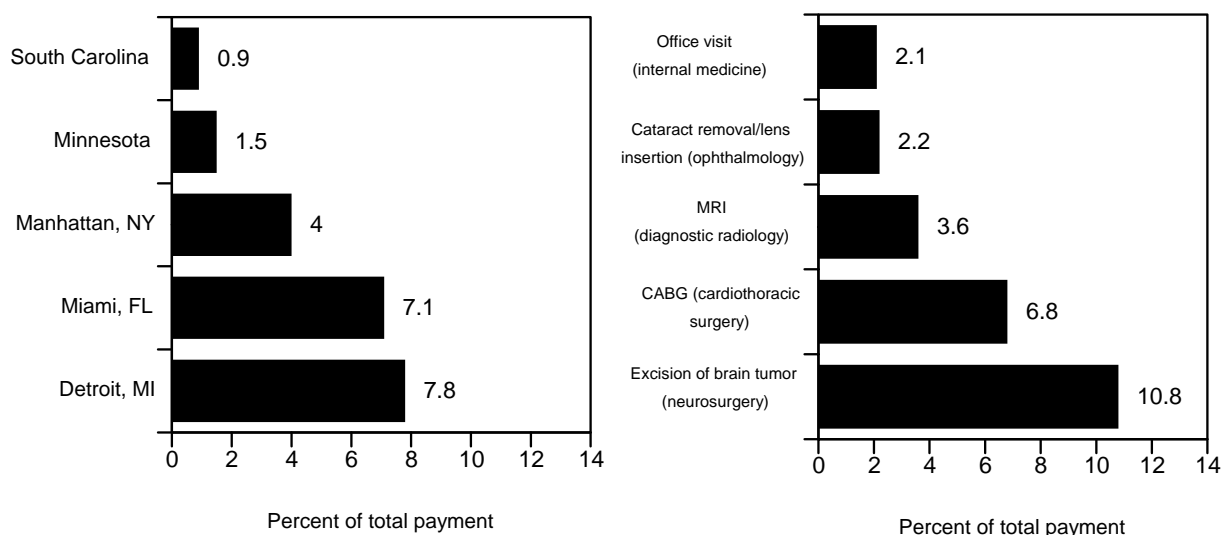
Chart 8-6. Quarterly changes in professional liability insurance premiums, 1990–2003



Source: Unpublished CMS data.

- Historically, the professional liability insurance (PLI) component of the Medicare Economic Index follows a strong cyclical pattern, illustrated by the changes in PLI premiums from 1990 to 2001. The cycle is generally characterized by the periods of low premiums, perhaps when insurers are building market share, and high premiums, perhaps when insurers are building reserves.
- Since 2001, changes in PLI premiums have departed from this cyclical pattern. The increase in the second quarter of 2003, estimated at 16.8 percent, was the highest in over a decade.
- Additional information related to this topic can be found in MedPAC issue brief, available at http://www.medpac.gov/publications/other_reports/Aug03_PLI%20_2pgrKH.pdf.

Chart 8-7. PLI payments vary by locality and service, as a percentage of total payments under the Medicare fee schedule, 2002

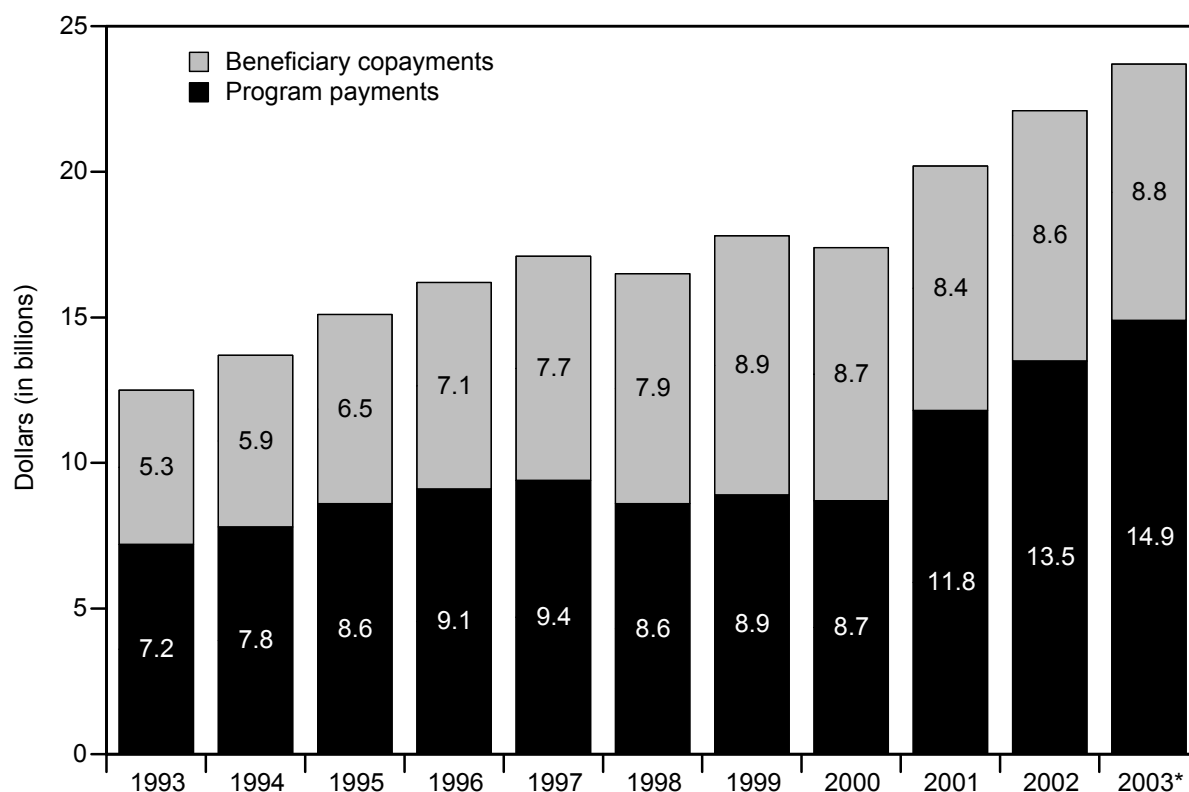


Note: PLI (professional liability insurance), CABG (coronary artery bypass graft). PLI payments for services are national averages.

Source: MedPAC analysis of claims for 100 percent of Medicare beneficiaries in 2002.

- Medicare accounts for physicians' costs for professional liability insurance (PLI) in three ways. One way is through the Medicare Economic Index (MEI), which is used to adjust payments equally to account for PLI costs across all physicians serving Medicare beneficiaries. The other two ways are through the physician fee schedule, which assigns relative value units (RVUs) to services and geographic practice costs indexes (GPCIs) to areas of the country. These two components of the fee schedule allow Medicare payments to account for PLI differentially—by service and by geographic area—based on PLI premium differences.
- The fee schedule's RVUs designate higher payments for services furnished by neurosurgeons and cardiothoracic surgeons, who bear higher PLI premiums. Similarly, the fee schedule's GPCIs adjust payments to physicians who practice in geographic areas with high PLI premiums, such as Detroit, Michigan. Given both of these factors, over 20 percent of Medicare's payments to a Detroit neurosurgeon under the fee schedule can be attributable to PLI, if a fairly high proportion of the neurosurgeon's practice consists of major procedures.
- Additional information and analysis related to this topic can be found in Chapter 3B of the MedPAC March 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3B.pdf.

Chart 8-9. Spending on all hospital outpatient services, 1993–2003



Note: * Estimate. Spending amounts are for services covered by the Medicare outpatient prospective payment system and those paid on separate fee schedules (such as ambulance services or durable medical equipment) or those paid on a cost basis (such as organ acquisition or flu vaccines). They do not include payments for clinical laboratory services.

Source: CMS, Office of the Actuary.

- Overall spending by Medicare and beneficiaries on hospital outpatient services almost doubled from calendar year 1993 to 2003. Growth was fast early in the 1990s, slowed in the mid-1990s, and accelerated again in 2001. The Office of the Actuary projects continued growth in total spending, averaging 8.6 percent per year from 2002 to 2007.
- A prospective payment system (PPS) for hospital outpatient services was implemented in August 2000. Services paid under the outpatient PPS represent about 90 percent of spending on all hospital outpatient services (excluding clinical laboratory services which is paid under a fee schedule).
- In 2001, the first full year of the outpatient PPS, spending under the PPS was \$18.4 billion, including \$10.4 billion by the program and \$8.0 billion in beneficiary cost sharing. By 2003, spending under the outpatient PPS is expected to rise to \$21.6 billion (\$13.3 billion program spending; \$8.3 billion beneficiary copayments). The outpatient PPS accounted for about 6 percent of total Medicare spending by the program and beneficiaries in 2003.
- Beneficiary cost sharing under the outpatient PPS is generally higher than for other sectors, about 38 percent in 2003. Chart 8-14 provides more detail on coinsurance.

Chart 8-10. Providers of hospital outpatient services

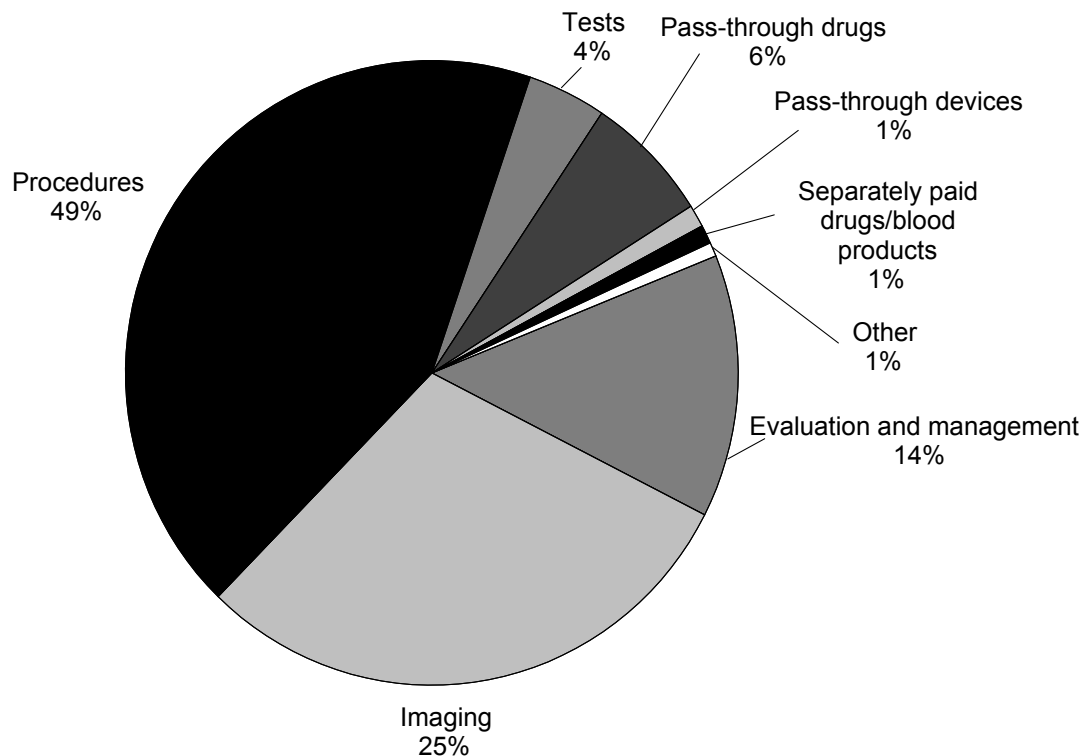
Year	Hospitals	Percent offering		
		Outpatient services	Outpatient surgery	Emergency services
1991	5,191	92%	79%	91%
1997	4,976	93	81	92
2001	4,347	94	84	93
2002	4,210	94	84	93

Note: Excludes long-term and alcohol- and drug-abuse hospitals, as well as critical access hospitals. Includes all others paid under the outpatient prospective payment system.

Source: MedPAC analysis of the Medicare provider of services file from CMS.

- While the number of hospitals has fallen over the past decade, the percent providing outpatient services, outpatient surgery, and emergency services has grown.
- Almost all hospitals provide outpatient (94 percent) and emergency (93 percent) services. The vast majority (84 percent) provides outpatient surgery.
- The share of hospitals providing outpatient services did not change after the introduction of the outpatient prospective payment system.

Chart 8-11. Payments under the Medicare hospital outpatient PPS, by type of service, 2002

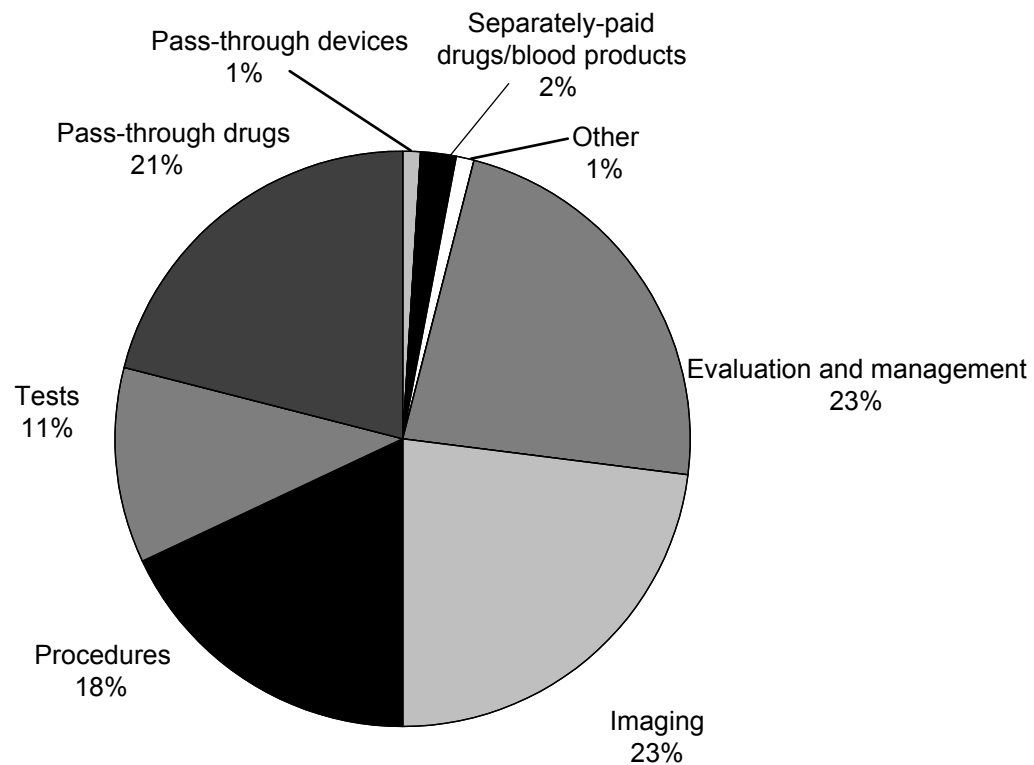


Note: PPS (prospective payment system). Payments include both program spending and beneficiary cost sharing, but do not include transitional corridor payments. Services are grouped into evaluation and management, procedures, imaging, tests, and other categories according to the Berenson-Eggers Type of Service classification developed by CMS. Pass-through drugs and devices and separately paid drugs and blood products are classified by their payment status indicator. Percents do not sum to 100 due to rounding.

Source: MedPAC analysis of the 100 percent special analytic file of outpatient PPS claims for April to December 2002 from CMS.

- Hospitals provide many different types of services in their outpatient departments, including emergency and clinic visits, imaging and other diagnostic services, laboratory tests, and ambulatory surgery.
- Procedures (e.g. endoscopies, surgeries, skin and musculoskeletal procedures) account for the greatest share of spending on services (49 percent), followed by imaging services (25 percent), and evaluation and management (14 percent).
- In 2002, pass-through drugs and devices accounted for 6 percent of spending. Payments for pass-through drugs include both the base payment and the pass-through amount.
- More information on pass-through payments can be found in Chapter 4 of the MedPAC March 2003 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/Mar03_Ch4.pdf.

Chart 8-12. Volume of services under the Medicare hospital outpatient PPS, by type of service, 2002



Note: PPS (prospective payment system). Services are grouped into evaluation and management, procedures, imaging, tests, and other categories according to the Berenson-Eggers type of service classification developed by CMS. Pass-through drugs and devices and separately-paid drugs and blood products are classified by their payment status indicator.

Source: MedPAC analysis of 100 percent special analytic file of outpatient PPS claims for April to December 2002 from CMS.

- Almost half of the services provided in hospital outpatient departments are evaluation and management or imaging services.
- The volume of services is distributed differently than payments. For example, procedures account for 18 percent of the volume, but 49 percent of the payments (see Chart 8-11).

Chart 8-13. Hospital outpatient services with the highest Medicare expenditures, 2002

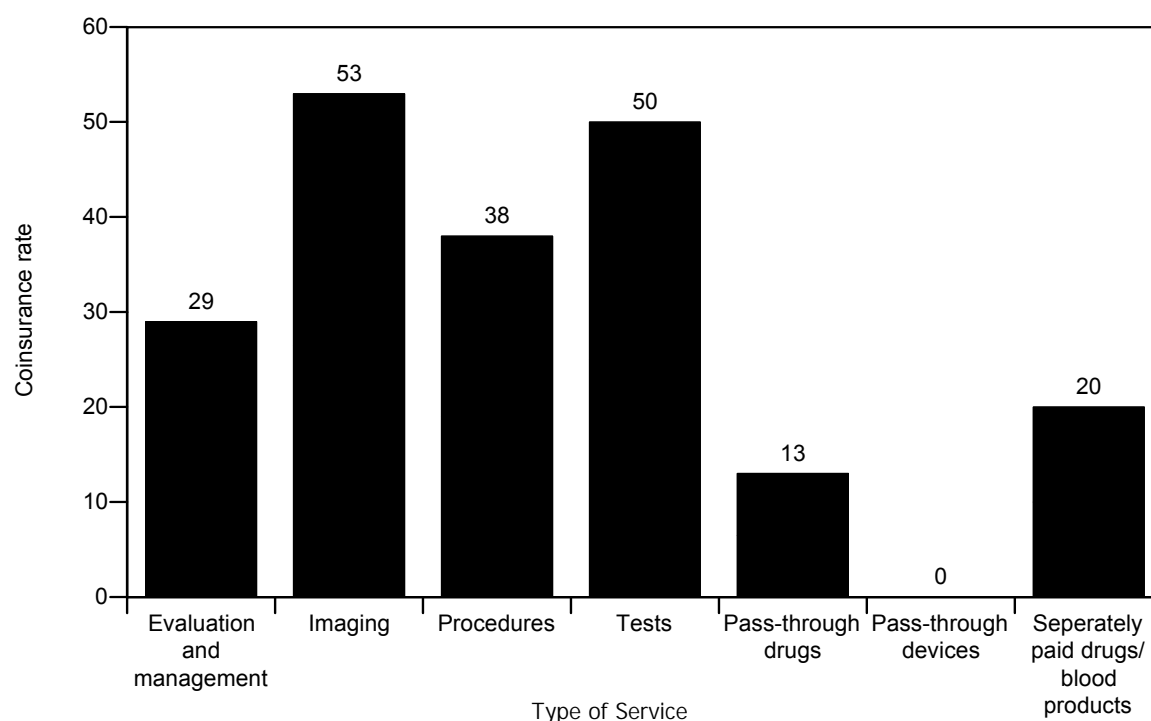
APC	Title	Share of payments
610, 611, 612	All emergency visits	7%
0246	Cataract procedures with lens insert	5
600, 601, 602	All clinic visits	4
0283	Computerized axial tomography (CAT) with contrast material	4
0080	Diagnostic cardiac catheterization	4
0143	Lower gastrointestinal endoscopy	3
0260	Level I plain film (X-ray) except teeth	3
0286	Myocardial scans	3
0332	Computerized axial tomography and computerized angiography	2
0300	Level I radiation therapy	2
0269	Level I echocardiogram except transesophageal	2
0120	Infusion therapy except chemotherapy	2
0336	Magnetic resonance imaging and magnetic resonance angiography	2
0141	Upper gastrointestinal procedures	2
0280	Level II angiography and venography except extremity	1
0337	MRI and magnetic resonance angiography without contrast	1
0154	Hernia/hydrocele procedures	1
0333	CAT and computerized angiography without contrast material followed by contrast	1
0325	Group psychotherapy	1
0359	Level II injections	1
Total		50

Note: APC (ambulatory payment classification). Payments include both program spending and beneficiary cost sharing.

Source: MedPAC analysis of the 100 percent special analytic file of outpatient prospective payment system claims for April to December 2002 from CMS.

- Although the outpatient prospective payment system covers thousands of services, expenditures are concentrated in a handful of categories that have high volume, high payment rates, or both.

Chart 8-14. Medicare coinsurance rates, by type of hospital outpatient service, 2002



Note: Services were grouped into categories of evaluation and management, procedures, imaging, and tests according to the Berenson-Eggers Type of Service classification developed by CMS. Pass-through drugs and devices and separately paid drugs and blood products are classified by their payment status indicators.

Source: MedPAC analysis of 100 percent special analytic file of 2002 outpatient prospective payment system claims and payment rates.

- Historically, beneficiary coinsurance payments for hospital outpatient services were based on hospital charges, while Medicare payments were based on hospital costs. As hospital charges grew faster than costs, coinsurance represented a large share of total payment over time.
- In adopting the outpatient prospective payment system (PPS), the Congress froze the dollar amounts for coinsurance. Consequently, beneficiaries' share of total payments will decline over time.
- The coinsurance rate is different for each service. Some services, such as imaging and tests, have very high rates of coinsurance—50 percent or more. Other services, such as clinic visits, have coinsurance rates of 20 percent.
- In 2002, the overall coinsurance rate was about 39 percent.
- A description of coinsurance under the outpatient PPS can be found in Chapter 9 of the MedPAC March 2001 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/Mar01%20Ch9.pdf.

Chart 8-15. Transitional corridor payments as a share of Medicare hospital outpatient payments, 2001 and 2002

Hospital group	2001		2002	
	Number of hospitals	Share of payments from transitional corridors	Number of hospitals	Share of payments from transitional corridors
All hospitals	3,388	2.3%	2,091	2.6%
Urban	2,121	2.1	1,337	2.3
Rural \leq 100 beds	990	4.7	584	6.4
Rural > 100 beds	272	0.8	167	1.8
Major teaching	249	4.9	137	4.7
Other teaching	700	1.2	436	1.6
Nonteaching	2,434	1.9	1,515	2.5

Note: A small number of hospitals could not be classified due to missing data. The 2002 file includes about 60 percent of hospitals. The 2002 results have not been adjusted to be representative of all hospitals.

Source: MedPAC analysis of Medicare Cost Report file from CMS.

- When Medicare implemented the hospital outpatient prospective payment system (PPS) in 2000, Medicare moved from paying hospitals based on their costs to a payment schedule based on average (median) costs for all hospitals.
- Recognizing that some hospitals might receive lower payments under the outpatient PPS than they had under the earlier system, the Congress included a transition mechanism, called transitional corridor payments. The corridors were designed to make up part of the difference between payments that hospitals would have received under the old payment system and those under the new outpatient PPS. To provide incentives for efficiency, Medicare did not compensate the full difference, except for rural hospitals with 100 or fewer beds, cancer hospitals, and children's hospitals.
- Transitional corridor payments represented 2.3 percent of total outpatient PPS payments in 2001, growing to 2.6 percent in 2002.
- Rural hospitals, particularly those with 100 or fewer beds, received a relatively large share of their payments from transitional corridors.
- Major teaching hospitals also reported greater shares of transitional corridor payments, receiving just under 5 percent of their payments from this source.

Chart 8-16. Three quarters of outpatient outlier payments were for services with payment rates of \$300 or less in 2002

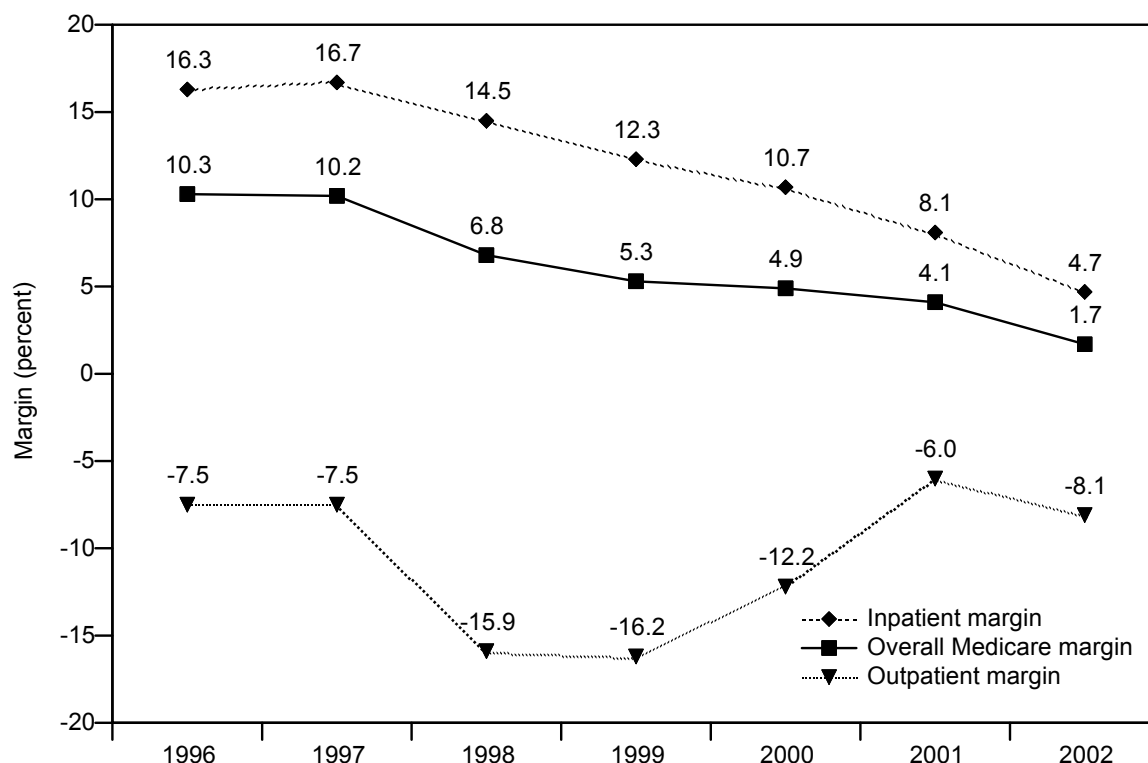
Payment rate	Percent of outlier payments	Percent of APC payments
Less than \$50	24.1%	10.9%
\$50 to \$99	9.7	10.3
\$100 to \$199	26.0	21.5
\$200 to \$299	15.0	11.4
\$300 to \$399	8.6	8.0
\$400 to \$499	2.1	3.4
\$500 to \$999	6.9	7.4
\$1000 or more	7.6	26.2

Note: APC (ambulatory payment classification). Percent of APC payments does not sum to 100 because some services (such as pass-through items) do not have a payment rate.

Source: MedPAC analysis of Special Analytic file of 100 percent of outpatient prospective payment system claims for April through December 2002 from CMS.

- The outpatient prospective payment system (PPS) has an outlier payment policy to provide additional payments to hospitals when they treat patients with extraordinarily high costs compared to their Medicare payments. The outlier policy is meant to serve as a form of insurance, protecting hospitals from large financial losses, and thereby protecting access to care for beneficiaries.
- Under the outpatient PPS, the outlier payments are based on the costs of an individual patient compared to the payment rate for the service, regardless of the level of the payment rate. Many services provided in outpatient departments have low payment rates.
- In 2002, 75 percent of outlier payments were for services with payment rates of \$300 or less. Services with payments less than \$50 accounted for 24 percent of outlier payments. At the other end of the spectrum, services with payment rates greater than \$1,000 account for less than 8 percent of outlier payments. This distribution of outlier payments indicates that, in general, outlier payments are not protecting hospitals from significant financial losses as intended.
- A discussion of the outlier policy under the outpatient PPS can be found in Chapter 3A of the MedPAC March 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3A.pdf.

Chart 8-17. Medicare hospital outpatient, inpatient, and overall Medicare margins, 1996–2002

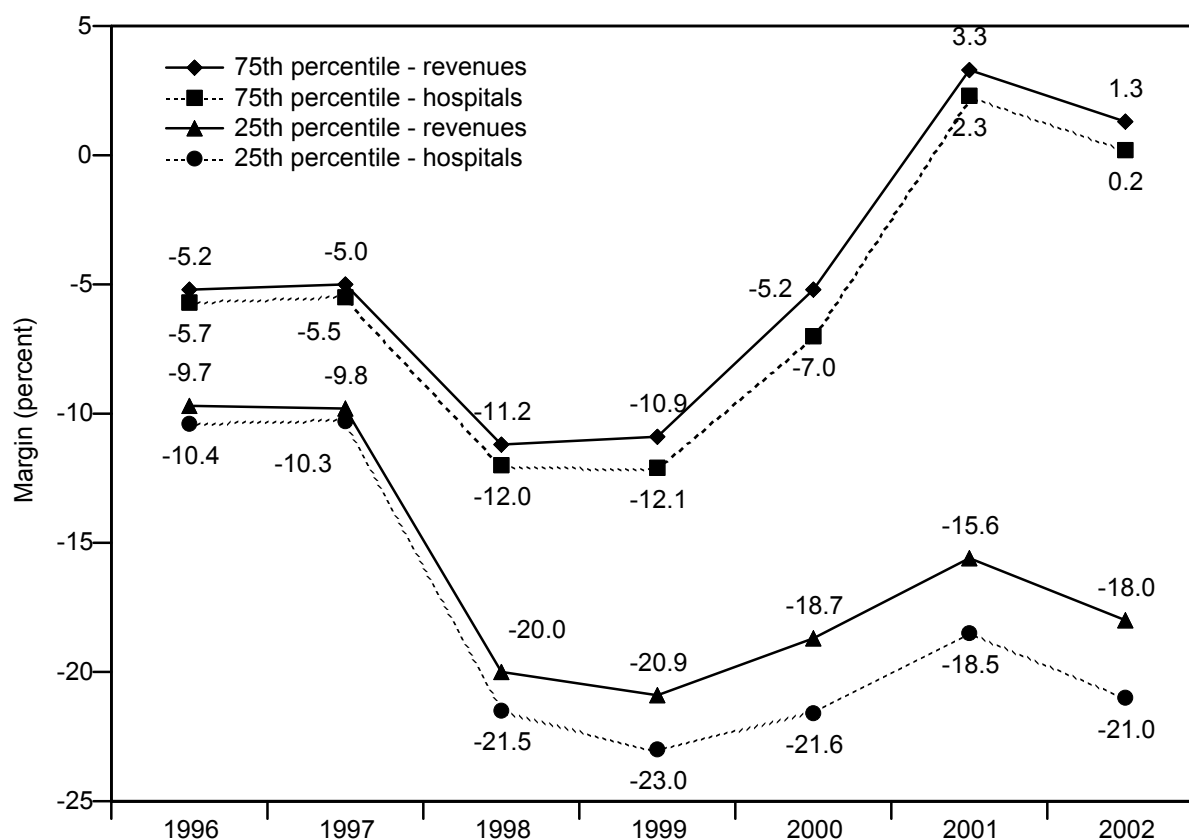


Note: A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and imputed for hospitals for which 2002 cost reports were not available. Analysis excludes critical access hospitals. Overall Medicare margins cover the costs and payments of hospital inpatient, outpatient, psychiatric and rehabilitation (not paid under the prospective payment system), skilled nursing facilities, and home health services, as well as graduate medical education.

Source: MedPAC analysis of Medicare cost report data (third quarter 2003) from CMS.

- Given hospital accounting practices, margins for hospital outpatient services must be considered in the context of Medicare payments and hospital costs for the full range of services provided to Medicare beneficiaries. When inpatient services were paid prospectively and outpatient services were paid based on costs, hospitals had a strong incentive to allocate joint costs to outpatient services on their cost reports.
- As a result, inpatient may be overstated and outpatient margins may be understated. These allocation decisions may have greater effects on the outpatient margin, however, because revenues for outpatient services represent a smaller share of the total (about 15 percent) than do inpatient revenues (about 75 percent). To avoid these allocation problems, MedPAC generally uses the overall Medicare margin to assess overall payment adequacy for hospital services.
- The dip in outpatient margins in 1998 is due primarily to the elimination of inadvertent overpayments. These overpayments resulted from an error in payment formulas for certain services that did not adequately account for beneficiary coinsurance when determining program payments.
- The improvement in outpatient margins from 1999 to 2001 is consistent with policies implemented under the outpatient prospective payment system that increased payments. Margins declined somewhat from 2001 to 2002.

Chart 8-18. Distribution of hospital outpatient margins, 1996–2002



Note: A margin is calculated as revenue minus costs, divided by revenue. The margins are presented for individual hospitals and weighted by revenues. Data are not available to weight by services or patients. Data are based on Medicare-allowable costs and imputed for hospitals for which 2002 cost reports were not available. Analysis excludes critical access hospitals.

Source: MedPAC analysis of Medicare cost report data (third quarter 2003) from CMS.

- Hospital outpatient margins vary. While the aggregate margin was –8.1 percent in 2002 (see Chart 8-17), 25 percent of hospitals had margins of –21.0 percent or lower, and 25 percent had margins of 0.2 percent or higher.
- When the margins are weighted by revenues, to account for where program dollars are spent, they rise. Using this measure, the 25th percentile was –18.0 percent and the 75th percentile was 1.3 percent in 2002.
- In the period since the implementation of the outpatient prospective payment system, margins rose both in the aggregate and for the 75th percentile, with a downturn in 2002. Gains were smaller for the 25th percentile.
- MedPAC-sponsored research suggests that hospital accounting practices have led to an overstatement of outpatient costs by as much as 15 to 20 percent. As a consequence, outpatient margins are probably understated. (Chapter 3A of the MedPAC 2004 March Report to the Congress is available at http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3A.pdf.)

Chart 8-19. Medicare-certified ASCs increased over 50 percent, 1997–2003

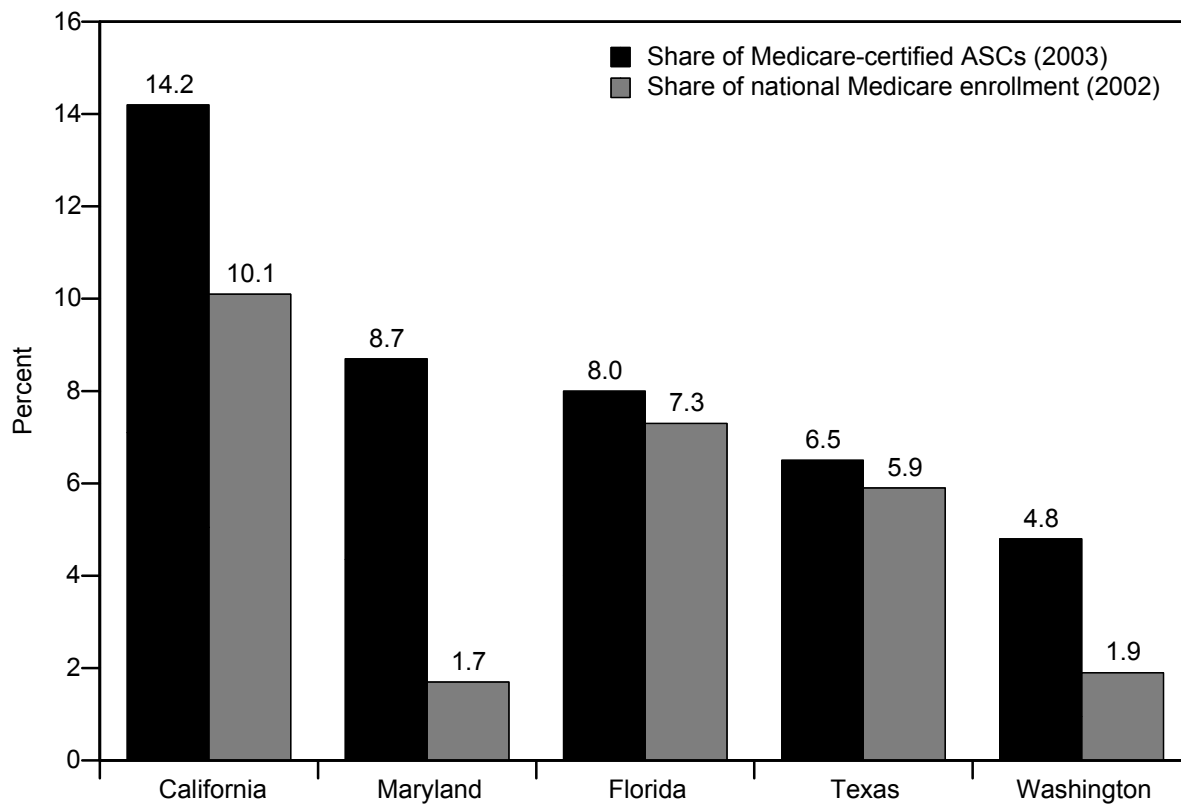
	1997	1998	1999	2000	2001	2002	2003
Medicare payments (billions of dollars)	1.0	1.1	1.2	1.4	1.6	1.9	2.2
Number of centers	2,462	2,644	2,786	3,028	3,371	3,597	3,735
New centers	237	228	162	295	445	309	185
Exiting centers	40	46	20	53	103	83	47
Net percent growth from previous year	8.7%	7.4%	5.4%	8.7%	11.3%	6.7%	3.8%
	Percent of all centers						
For profit	93%	94%	94%	94%	94%	95%	95%
Nonprofit	6	6	6	6	5	5	5
Urban	90	89	89	88	88	87	87
Rural	10	11	11	12	12	13	13

Note: ASC (ambulatory surgical center). Medicare payments include program spending and beneficiary cost sharing for ASC facility services. Payments for 2003 are projected. For 2003, data on the number of facilities are through June. For all other years, data are through December. Totals may not sum to 100 due to rounding.

Source: MedPAC analysis of provider of services file from CMS, payment data from CMS, Office of the Actuary.

- Ambulatory surgical centers (ASCs) are distinct entities that only furnish outpatient surgical services not requiring an overnight stay. To receive payments from Medicare, ASCs must meet Medicare's conditions of coverage, which specify minimum clinical standards.
- The number of Medicare-certified ASCs grew at an average annual rate of 8 percent from 1997 through the first half of 2003. Each year from 1997 through 2002, an average of 279 new Medicare-certified facilities entered the market, while an average of 58 closed or merged with other facilities.
- The overwhelming majority of Medicare-certified ASCs are for-profit facilities and are located in urban areas.

Chart 8-20. Over 40 percent of Medicare-certified ASCs are located in 5 states, 2003



Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of provider of services file from CMS, enrollment data from CMS, Office of the Actuary.

- Five states accounted for 42 percent of Medicare-certified ambulatory surgical centers in 2003, 38 percent of ASC services received by beneficiaries (2002), but only 27 percent of Medicare beneficiaries (2002).

Chart 8-21. Ophthalmology and gastroenterology procedures accounted for over two-thirds of ASC services provided to beneficiaries, 2002

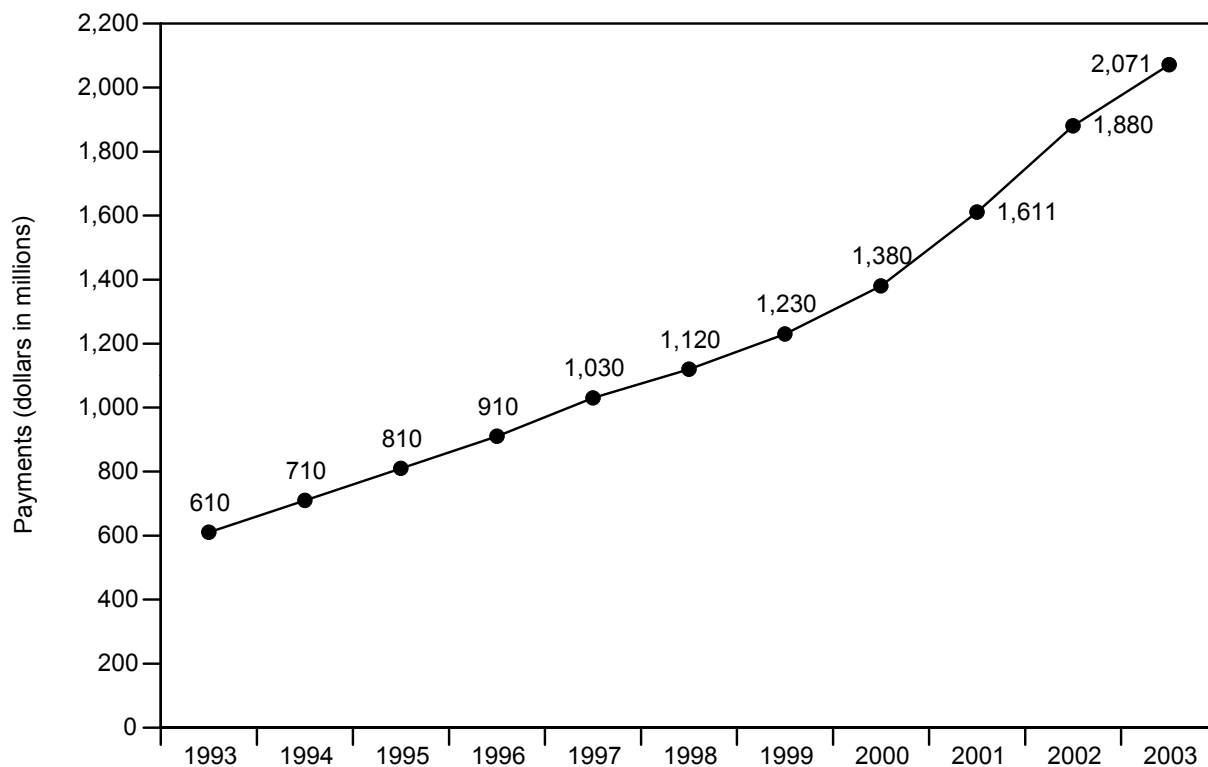
Procedure category	Medicare volume (percent of total)	Medicare ASC payments (percent of total)	Medicare payments (millions)	Percent volume growth, 2001–2002
Cataract removal and lens insertion	27.4%	47.5%	\$904	11.5%
Colonoscopy	19.5	14.8	282	27.8
Other eye procedures	11.3	9.3	176	10.9
Minor procedures – musculoskeletal	11.0	5.8	111	28.9
Upper gastrointestinal endoscopy	10.3	6.7	128	20.1
Other ambulatory procedures	4.5	3.0	56	17.9
Ambulatory procedures – musculoskeletal	3.5	2.6	50	18.8
Cystoscopy	2.8	1.9	36	9.6
Ambulatory procedures – skin	1.6	1.2	24	9.7
Arthroscopy	1.6	1.5	29	-0.2
Other services	6.5	5.6	106	29.0
Total	100.0	100.0	1,902	18.2

Note: ASC (ambulatory surgical center). Medicare payments include program spending and beneficiary cost sharing. Other eye procedures includes after-cataract laser surgery. Minor procedures – musculoskeletal includes interventional pain management procedures (such as epidural injection and facet joint block), soft tissue biopsy, and tumor excision. Other ambulatory procedure includes breast biopsy, nasal polyp excision, abscess drainage, nerve graft, and ear surgery. Ambulatory procedures – musculoskeletal includes hammertoe operation, arthrotomy, tenotomy, and tendon repair. Ambulatory procedures – skin includes debridement, excision of lesion, wound repair, and skin graft. Other services includes other endoscopic, orthopedic, eye, and skin procedures, as well as hernia repair. Totals may not sum to 100 due to rounding.

Source: MedPAC analysis of the 5 percent Standard Analytic File of ASC claims from CMS, 2001 and 2002, and the Berenson-Eggers Type of Service classification scheme developed by CMS.

- Taken together, eye procedures (cataract removal and lens insertion and other eye procedures) account for almost 40 percent of the volume of ASC procedures and almost 60 percent of Medicare payments for ASC services.
- Colonoscopy and upper gastrointestinal endoscopy account for 30 percent of volume and 20 percent of Medicare payments.
- CMS maintains a list of over 2,400 surgical procedures eligible for facility payment by Medicare when performed in an ASC. Procedures must meet specific clinical and volume criteria to be added to this list. The list of approved procedures was most recently updated in 2003.

Chart 8-22. Medicare payments to ASCs more than tripled, 1993–2003

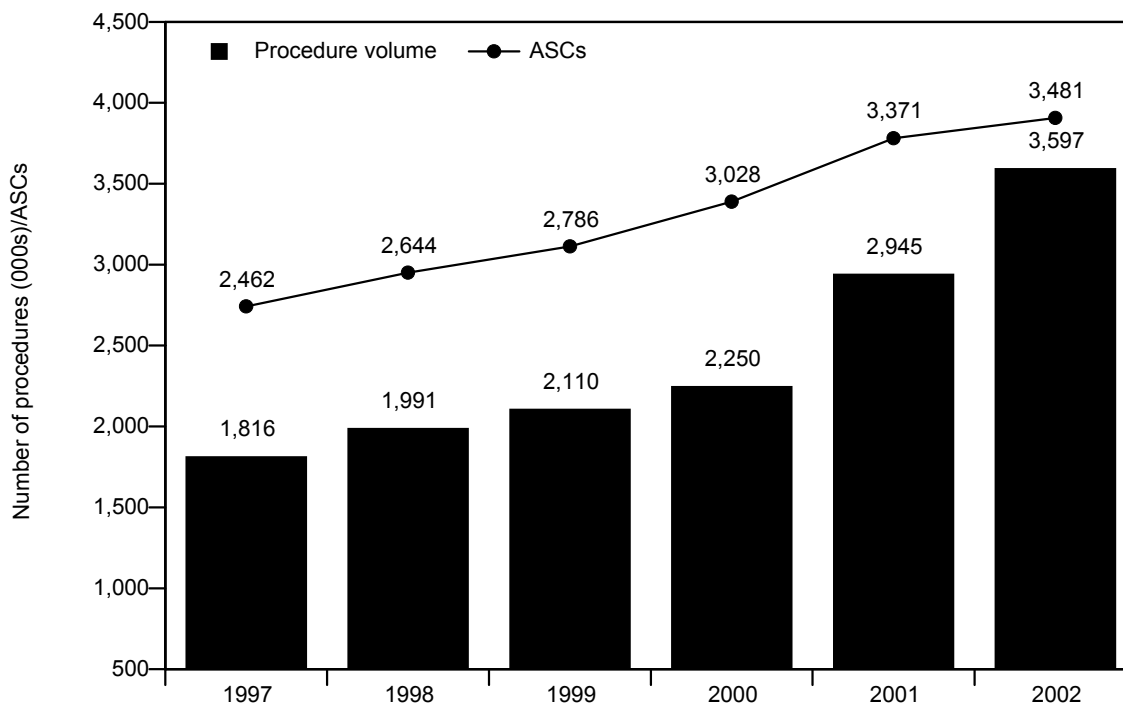


Note: ASC (ambulatory surgical center). Medicare payments include program spending and beneficiary cost sharing for ASC facility services. Average annual growth of payments (1993–2003) equals 13 percent.

Source: CMS, Office of the Actuary, 2004.

- Payments to ambulatory surgical centers increased from \$610 million to \$2 billion in 10 years, but are still less than 1 percent of total Medicare spending.
- More information on Medicare's payment policy for ASC services can be found in Chapter 3F of MedPAC's March 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3F.pdf.

Chart 8-23. ASCs and the volume of ASC procedures have grown rapidly, 1997–2002



Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of provider of services file, 5 percent Standard Analytic File of ASC claims from CMS.

- Between 1997 and 2002, the volume of ambulatory surgical center (ASC) procedures provided to Medicare beneficiaries increased by 90 percent (14 percent per year, on average), while the number of Medicare-certified ASCs increased by 46 percent (8 percent per year, on average).
- The number of ASC procedures per thousand beneficiaries grew from 47 to 86 (82 percent) during the same period.

Chart 8-24. Over half of most common ambulatory surgical procedures were performed in hospital outpatient departments, 2001

Procedure category	Share of ambulatory surgical volume, all settings	Share of volume, by setting		
		Outpatient departments	Physician offices	ASCs
Colonoscopy	16.0%	70.8%	4.3%	24.9%
Cataract removal and lens insertion	12.5	47.7	0.5	51.8
Minor procedures—musculoskeletal	10.7	48.1	31.1	20.8
Upper gastrointestinal endoscopy	9.5	72.0	4.5	23.5
Cystoscopy	9.0	28.7	63.8	7.5
Ambulatory procedures—skin	7.9	42.4	52.6	5.0
Other ambulatory procedures	7.3	69.8	16.5	13.8
Other eye procedures	6.9	27.5	33.6	39.0
Other minor procedures	5.0	30.1	63.3	6.5
Ambulatory procedures—musculoskeletal	3.4	59.8	17.4	22.9
Total	88.1	53.1	24.1	22.8

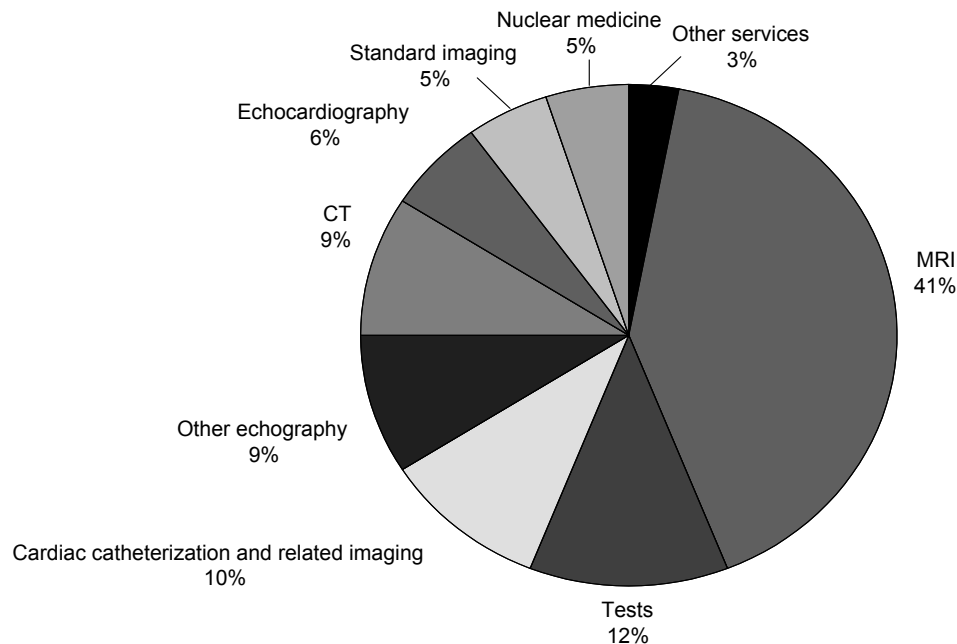
Note: ASC (ambulatory surgical center). Table only includes ambulatory surgical procedures that are on the list of services payable by Medicare when performed in an ASC. Procedure categories are arranged by their share of ambulatory surgical volume across all settings, from highest to lowest. Minor procedures – musculoskeletal includes interventional pain management procedures (such as epidural injection and facet joint block), soft tissue biopsy, and tumor excision. Ambulatory procedures – skin includes skin debridement, excision of lesion, wound repair, and skin graft. Other ambulatory procedures includes breast biopsy, nasal polyp excision, abscess drainage, and nerve graft. Other eye procedures includes after-cataract laser surgery. Other minor procedures includes nasal, oral, urological, and nerve procedures. Ambulatory procedures – musculoskeletal includes hammertoe operation, arthrotomy, tenotomy, and tendon repair.

Source: MedPAC and RAND analysis of the 5 percent Standard Analytic Files of physician, outpatient department, and ASC claims from CMS and the Berenson-Eggers Type of Service classification scheme developed by CMS.

- Outpatient departments account for 71 percent of colonoscopies—the most common ambulatory surgical procedure.
- Over half of cataract removal and lens insertion procedures are provided in ASCs.
- Physician offices account for a majority of cystoscopies, ambulatory procedures—skin, and other minor procedures.

Chart 8-25. Medicare spending for independent diagnostic testing facility services, by type of service, 2002

Total spending = \$741 million

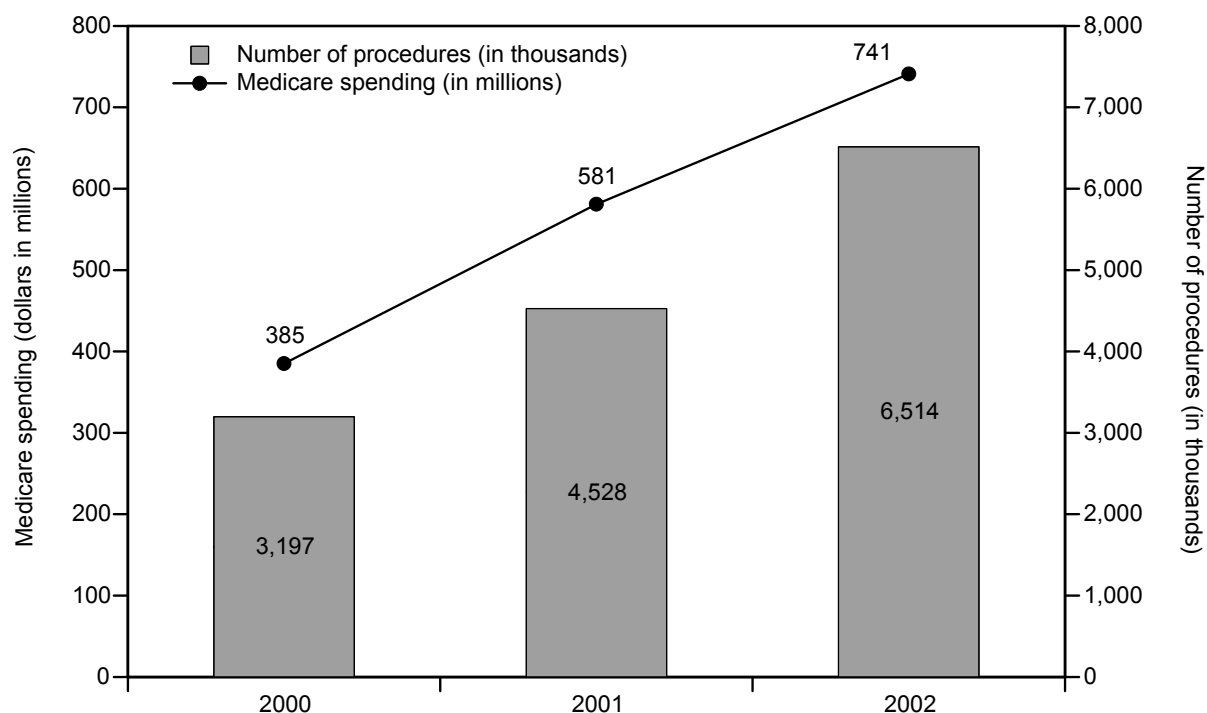


Note: CT (computed tomography), MRI (magnetic resonance imaging). Tests include electrocardiogram monitoring and cardiovascular stress tests but excludes clinical laboratory tests. Cardiac catheterization includes placement of the catheter and the related imaging procedure, such as angiogram.

Source: MedPAC analysis of 5 percent Standard Analytic File of independent diagnostic testing facility claims from CMS.

- Independent diagnostic testing facilities (IDTFs) are independent of a hospital and physician office and only provide outpatient diagnostic services. Medicare also pays for outpatient diagnostic services provided by hospital outpatient departments and physician offices. Medicare pays for IDTF services under the physician fee schedule at the same rates as physician offices.
- Imaging procedures—every category except for tests and other services—account for 85 percent of Medicare spending for IDTF services (\$630 million).
- CMS applies specific rules to IDTFs that do not apply to physician offices that provide diagnostic tests. For example, IDTFs must have supervising physicians who oversee testing quality and nonphysician staff who are licensed or certified. However, enforcement of these standards is not rigorous: after initial enrollment in Medicare, IDTFs are generally not subject to periodic survey and certification.

Chart 8-26. Medicare volume and spending for independent diagnostic testing facility services doubled between 2000 and 2002

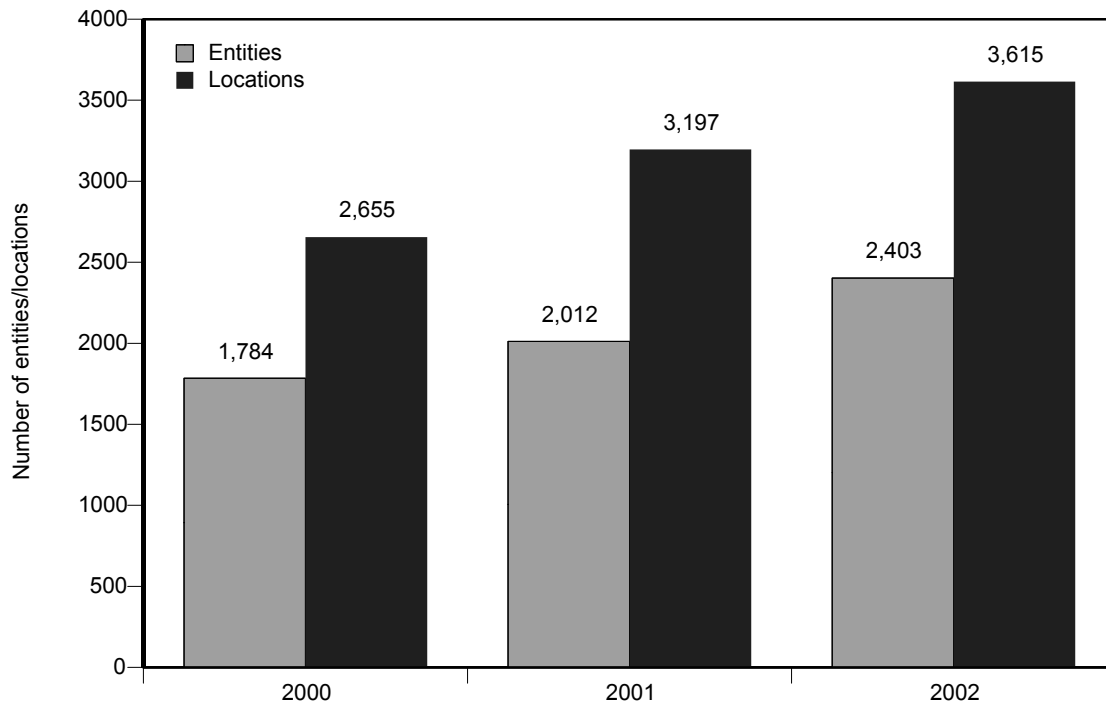


Note: Medicare spending includes program spending and beneficiary cost sharing.

Source: MedPAC analysis of 5 percent Standard Analytic File of independent diagnostic testing facility claims from CMS.

- Medicare spending for independent diagnostic testing facility (IDTF) services nearly doubled between 2000 and 2002, from \$385 million to \$741 million. Most IDTF services are imaging procedures. Medicare spending for all imaging services paid under the physician fee schedule grew at half that rate—27 percent—during the same period.
- The categories of IDTF services that experienced the fastest spending growth were: cardiac catheterization and related imaging procedures (271 percent), computed tomography (164 percent), and nuclear medicine (121 percent).
- Total Medicare spending (program spending and beneficiary cost sharing) for imaging services paid under the physician fee schedule was \$8.1 billion in 2002; 8 percent of that amount was provided in IDTFs.

Chart 8-27. The number of independent diagnostic testing facilities grew rapidly between 2000 and 2002



Note: An entity refers to a unique business entity. Each entity may have multiple fixed or mobile locations. On average, each entity had 1.5 locations in 2002.

Source: MedPAC analysis of 5 percent Standard Analytic File of independent diagnostic testing facility claims.

- Using Medicare claims data, we identified 2,400 independent diagnostic testing facility (IDTF) business entities in 2002. Each entity may have more than one (fixed or mobile) location—over 3,600 IDTF locations submitted Medicare claims in 2002.
- Between 2000 and 2002, the number of IDTF entities grew by 16 percent per year, on average, and the number of locations increased by 17 percent per year, on average. By comparison, Medicare spending for IDTF services grew by almost 40 percent per year, on average, during this period.

Web links. Ambulatory care

Physicians

- Chapter 3B of the MedPAC March 2004 Report to the Congress provides additional information on physician services.

http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3B.pdf

- The 2004 Annual Report of the Boards of Trustees of the Hospital Insurance and Supplementary Medical Insurance Trust Funds provides details on historical and projected spending on physician services.

<http://www.cms.hhs.gov/publications/trusteesreport/2004/tr.pdf>

- Congressional testimony by the Chairman of MedPAC on May 5, 2004 discusses payment for physician services in the Medicare program.

http://www.medpac.gov/publications/congressional_testimony/050504_SGRTestimony_EC.pdf

Hospital outpatient services

- Chapter 3A of the MedPAC March 2004 Report to the Congress provides additional information on hospital outpatient services, including outlier and transitional corridor payments.

http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3A.pdf

- A description of coinsurance under the outpatient PPS can be found in Chapter 9 of the MedPAC March 2001 Report to the Congress.

http://www.medpac.gov/publications/congressional_reports/Mar01%20Ch9.pdf

- More information on new technology and pass-through payments can be found in Chapter 4 of the MedPAC March 2003 Report to the Congress.

http://www.medpac.gov/publications/congressional_reports/Mar03_Ch4.pdf

Ambulatory surgical centers

- Chapter 3F of the MedPAC March 2004 Report to the Congress provides additional information on ambulatory surgical centers.

http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3F.pdf

SECTION

9

Post-acute care
Skilled nursing facilities
Home health services

Chart 9-1. The number of post-acute care providers generally continues to grow

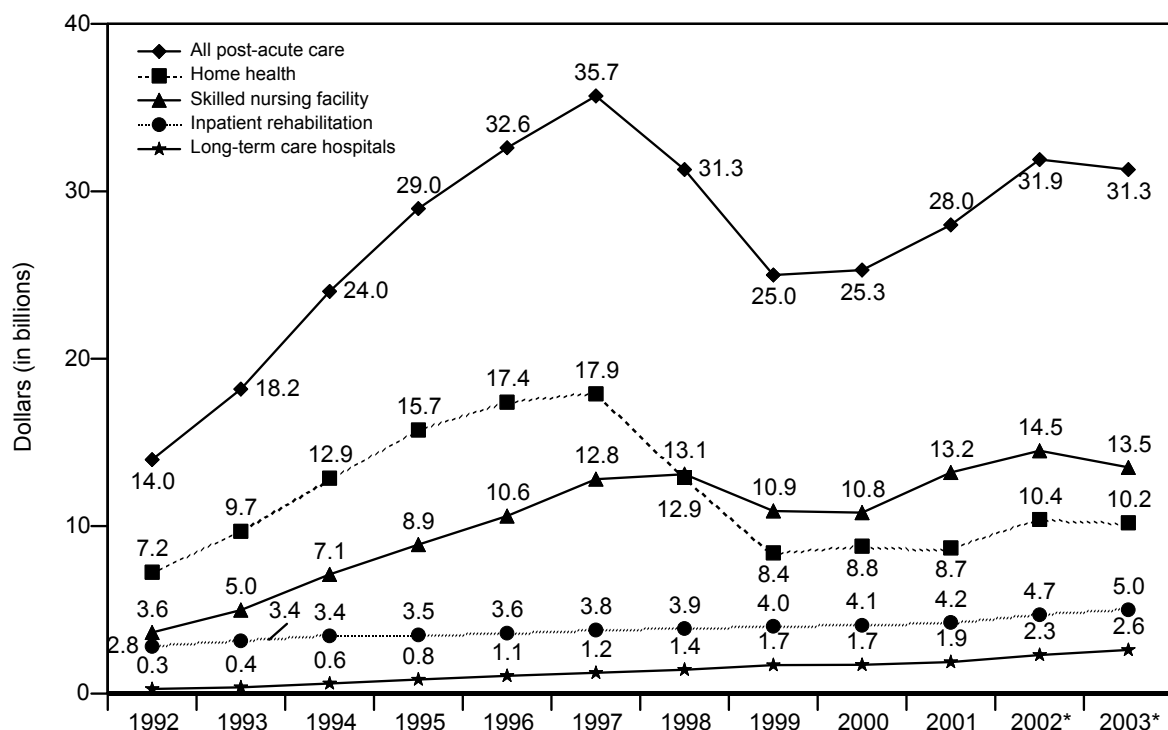
	1992	1994	1996	1998	2000	2002	2004
Skilled nursing facilities*	12,303	13,945	14,548	16,079	16,275	15,089	15,784
Home health agencies	6,447	8,003	9,808	9,284	7,317	6,888	7,148
Inpatient rehabilitation	907	1,001	1,031	1,078	1,102	1,181	1,206
Long-term care hospitals	97	146	183	209	240	286	307

Note: * Includes swing bed hospitals.

Source: Provider of service file from CMS.

- The number of post-acute care providers increased across all settings from 1992 to 2004.
- The number of skilled nursing facilities has declined since 2000 despite an increase from 2002-2004.
- The number of home health agencies increased by 50 percent from 1992 to their peak in 1996 and then dropped back to 1992 levels. This may be due to many factors including: the interim payment system, increased program integrity scrutiny, surety bond requirements, and other factors. The number has begun to increase again in the most recent period.
- Inpatient rehabilitation facilities increased by one-third from 1992 to 2004.
- The number of long-term care hospitals tripled from 1992 to 2004.
- More information on post-acute care can be found in Chapter 5 of the MedPAC June 2003 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/June03_Ch5.pdf and Chapter 5 of the MedPAC June 2004 Report to Congress at http://www.medpac.gov/publications/congressional_reports/June04_ch5.pdf.

Chart 9-2. Medicare spending for post-acute care, by setting, 1992–2003

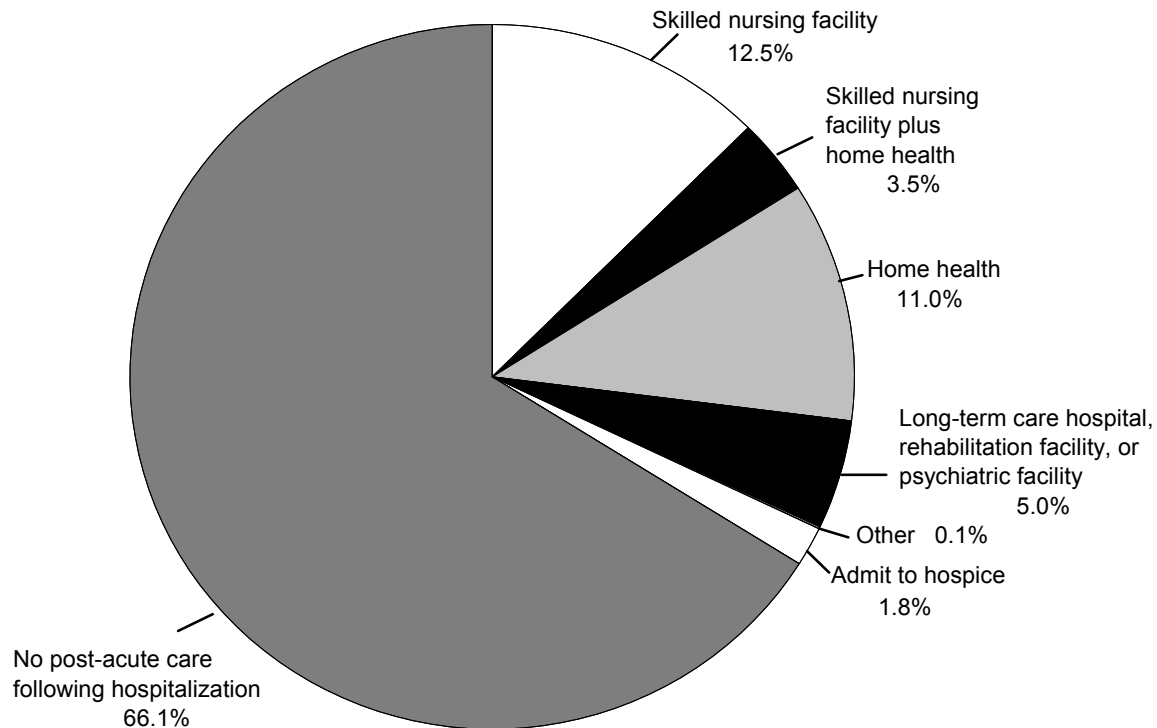


Note: Dollars are program spending figures and do not include beneficiary copayments.
 *Spending for 2002 and 2003 are estimated.

Source: CMS, Office of the Actuary, 2003.

- Total spending for post-acute care increased rapidly at 21 percent per year from 1992 to 1997. During this period, spending for long-term care hospitals grew the fastest—at 35 percent per year—while spending for skilled nursing facility care increased at 29 percent per year, home health care increased at 20 percent per year, and inpatient rehabilitation increased at 6 percent per year.
- Total spending for post-acute care decreased between 1997 and 2000—by almost 30 percent—due largely to a 50 percent decrease in spending for home health services. Additional reasons include: The interim payment system, increased program integrity scrutiny, and other factors. For 2003, CMS estimated that total spending for post-acute care is at about 1995 levels.
- Post-acute care currently makes up about 11 percent of Medicare’s total spending.
- More information can be found in Chapter 5 of the MedPAC June 2004 Report to the Congress, and Chapters 2C and 2D of the MedPAC March 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/June04_Ch5.pdf and http://www.medpac.gov/publications/congressional_reports/Mar04_Ch2.pdf.

Chart 9-3. About one-third of hospital patients go on to use post-acute care

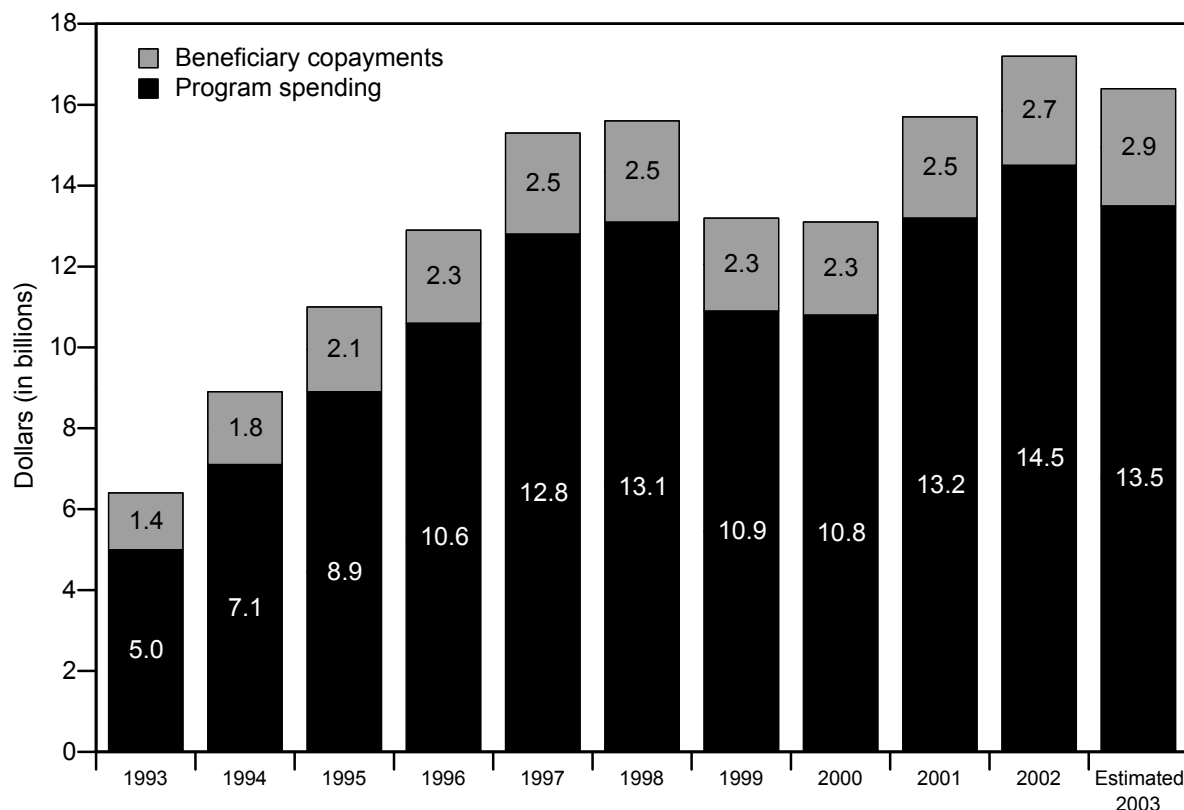


Note: Long-term care hospital, rehabilitation facility, or psychiatric facility includes beneficiaries who used other post-acute settings following their use of these settings. Other includes all other "mixed" episodes, e.g. home health followed by skilled nursing facility.

Source: Medicare beneficiaries' use of post-acute care 1996 compared to 2001. Report submitted to MedPAC by Christopher Hogan, Direct Research, May 12, 2004.

- The most common single post-acute care destination for beneficiaries discharged from acute inpatient care hospitals is a skilled nursing facility.
- Though some episodes are complicated and involve multiple settings, the most common episode includes only one post-acute setting.

Chart 9-4. Medicare spending for skilled nursing facility services generally increased over the decade 1993–2003



Note: Spending is for Part A services.

Source: CMS, Office of the Actuary, 2004.

- Total Medicare spending on skilled nursing facility (SNF) services grew rapidly (averaging 19 percent per year) from fiscal year 1993 through fiscal year 1998.
- In fiscal year 1999, immediately following the implementation of the SNF prospective payment system, total Medicare spending on SNF services fell from \$15.6 billion to \$13.2 billion. Prior to fiscal year 1998, Medicare paid SNFs based on their costs, subject to some limits.
- A number of factors contributed to the increase in total Medicare spending for SNF services from fiscal year 2000 to fiscal year 2002, including increases in the use of SNF services and increases in payment rates over the period. Payment rate increases occurred both because of annual updates and because of temporary payment add-ons mandated in the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000. Total SNF expenditures increased from \$13 billion in 2000 to \$17 billion in 2002.
- The decrease in total spending (about \$800 million) estimated for fiscal year 2003 is due mostly to the expiration of two temporary payment add-ons at the end of fiscal year 2002.

Chart 9-5. Medicare skilled nursing facility use has remained relatively stable between 1997 and 2001

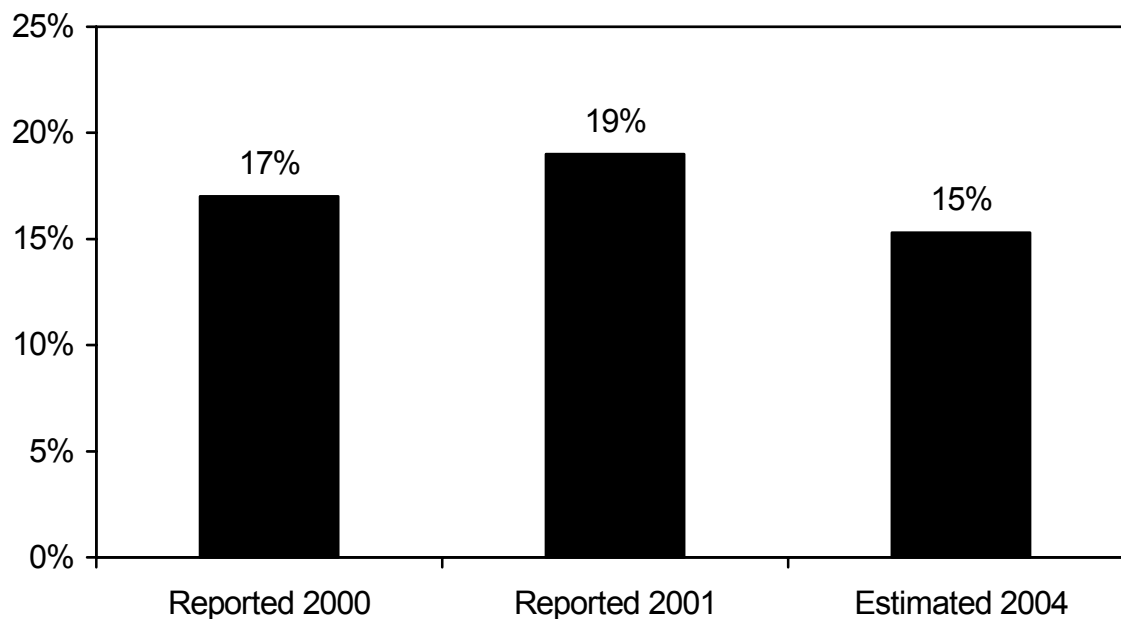
Year	Admissions		Days	
	Number (thousands)	Per 1,000 enrollees	Number (millions)	Per admission
1997	1,890	49	47.2	25.0
1998	1,885	49	44.5	23.6
1999	1,796	46	42.4	23.6
2000	1,824	46	43.8	24.0
2001	1,950	49	47.9	24.6
Average annual increase	0.8%	0.0%	0.4%	-0.4%

Note: Data include facilities in Puerto Rico, Virgin Islands, and "unknown." Data do not include swing bed units.

Source: CMS, Office of Research, Development, and Information, from Inpatient SNF MedPAR stay records.

- The number of Medicare admissions to a skilled nursing facility (SNF) remained relatively stable from 1997 to 2001. But admissions decreased by about 5 percent between 1997 and 1999 (the start of the SNF prospective payment system) then increased from 2000 to 2001. The number of Medicare-covered days in SNFs followed a similar pattern.
- The average length of stay in SNFs decreased by almost a day and a half from 1997 to 1998, but it increased again by one day between 1999 and 2001.

Chart 9-6. Medicare margins for freestanding skilled nursing facilities continue to be in the double digits, 2000, 2001, and estimated 2004



Note: Margin is calculated as revenue minus costs, divided by revenue.

Source: MedPAC analysis of Medicare cost report data from CMS.

- The Medicare margin for freestanding skilled nursing facilities (SNFs) increased 2 percentage points between fiscal year 2000 and fiscal year 2001. The primary reason for this increase was the introduction of a 16.66 percent add-on to the nursing component of SNFs' base payment rate in April 2001, mandated by the Medicare, Medicaid, and SCHIP Benefits Improvement & Protection Act of 2000.
- Additional information on Medicare margins for skilled nursing facilities can be found in Chapter 3C of the MedPAC March 2004 Report to the Congress, Chapter 2C of the MedPAC March 2003 Report to the Congress, and Chapter 2D of the MedPAC March 2002 Report to the Congress, available at
http://www.medpac.gov/publications/congressional_reports/mar04_CH3C.pdf;
http://www.medpac.gov/publications/congressional_reports/Mar03_Ch2C.pdf;
http://www.medpac.gov/publications/congressional_reports/Mar02_Ch2D.pdf.
- The Medicare margin in fiscal year 2004 is about 15.3 percent. This represents the combination of three changes in the payment rates since fiscal year 2001:
 - The expiration of two temporary payment add-ons at the end of fiscal year 2002.
 - An administration action resulting in a 3.26 percent increase in SNFs' fiscal year 2004 base rates to correct for errors in forecasting the SNF market basket index for fiscal years 2000 through 2003.
 - A full 3 percent update in these rates for fiscal year 2004.

Chart 9-7. The highest percentage of Medicare-covered SNF days were in “very high” and “high” rehabilitation RUG–III groups in 2001

RUG–III group	Percent of Medicare days
Rehabilitation	75.3%
Ultra high, 16–18 ADL	1.0
Ultra high, 9–15 ADL	3.7
Ultra high, 4–8 ADL	1.0
Very high, 16–18 ADL	2.3
Very high, 9–15 ADL	11.3
Very high, 4–8 ADL	4.2
High, 13–18 ADL	14.9
High, 8–12 ADL	13.7
High, 4–7 ADL	4.6
Medium, 15–18 ADL	5.6
Medium, 8–14 ADL	9.5
Medium, 4–7 ADL	3.0
Low, 14–18 ADL	0.2
Low, 4–13 ADL	0.3
Extensive services	7.8
7–18 ADL, 4–5 services	3.2
7–18 ADL, 2–3 services	4.4
7–18 ADL, 0–1 services	0.2
Special care	7.1
17–18 ADL	1.6
15–16 ADL	2.2
7–14 ADL	3.3
Clinically complex	6.9
17–18 ADL, depression	0.2
17–18 ADL, no depression	0.7
12–16 ADL, depression	0.6
12–16, no depression	2.2
4–11, depression	0.7
4–11, no depression	2.5
Nonskilled RUGs	2.7

Note: ADL (activity of daily living), RUG–III (resource utilization group, version III), SNF (skilled nursing facility).

Source: MedPAC analysis of Medicare data from CMS, 2001.

- Three-quarters of the 48 million Medicare-covered days in skilled nursing facilities (SNFs) were in rehabilitation RUG-III groups in 2001.
- Medicare-covered SNF days were concentrated in two of the “high” rehabilitation groups (14.9 percent and 13.7 percent) and in one of the “very high” rehabilitation groups (11.3 percent).
- Extensive service, special care, and clinically complex RUG-III groups each accounted for about 7 to 8 percent of Medicare-covered days.

Chart 9-8. Hospital-based SNF patients tended to be younger than freestanding SNF patients in fiscal year 2000

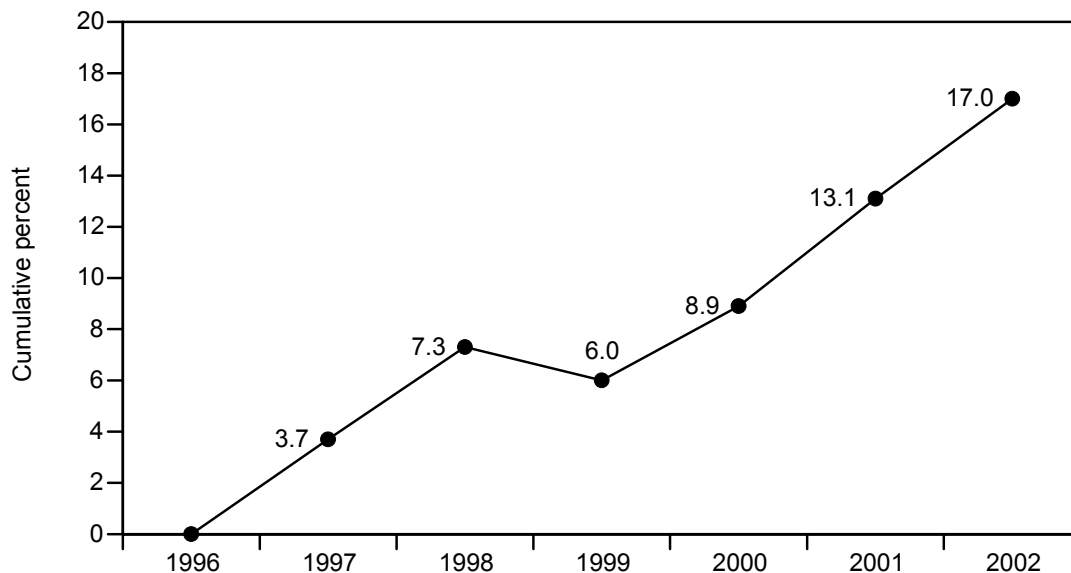
Characteristic	Type of facility	
	Freestanding	Hospital based
Female	66.3%	65.7%
Male	33.7	34.3
Age		
<65	4.9	6.2
65–74	16.9	23.6
75–84	40.7	42.4
85+	37.5	27.8
Medicare status		
Aged	94.4	93.2
Disabled	4.4	5.6
ESRD	1.2	1.3

Note: SNF (skilled nursing facility), ESRD (end-stage renal disease).

Source: MedPAC analysis of the Skilled Nursing Facility Stay File, 2000, from CMS.

- Hospital-based SNFs treat a higher proportion of younger patients (younger than 74 years old), while freestanding SNFs treat a higher proportion of patients 85 years old or older.
- Hospital-based SNFs treat a higher proportion of beneficiaries who qualify for Medicare because of a disability rather than freestanding SNFs.

Chart 9-9. Routine costs per day in freestanding SNFs increased 17 percent from 1996 to 2002

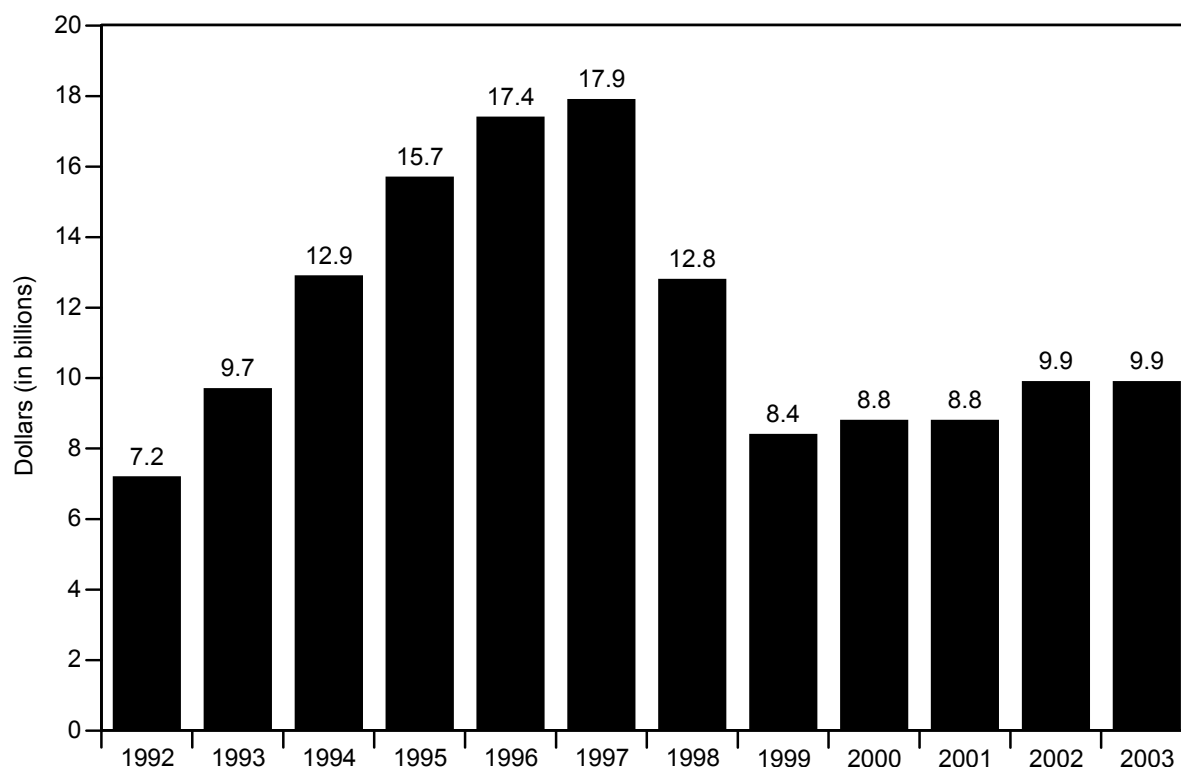


Note: SNF (skilled nursing facility). Routine cost growth per day was calculated from year to year among cohorts of freestanding SNF facilities that were submitting cost reports in both years.

Source: MedPAC analysis of Medicare cost report data from CMS.

- Routine costs per day in freestanding skilled nursing facilities (SNFs) declined by 1.3 percent between fiscal year 1998 and fiscal year 1999, the first year of the SNF prospective payment system. In fiscal years 2000 through 2002, routine cost growth returned to its previous level of between 3 and 4 percent per year.

Chart 9-10. Spending for home health care, 1992–2003



Source: CMS, Office of the Actuary, 2004.

- Medicare home health care spending grew at an average annual rate of 20 percent from 1992 to 1997. During that period, the payment system was cost based. Eligibility had been loosened just before this period and enforcing the program's standards became more difficult.
- Spending began to fall in 1997, concurrent with the introduction of the interim payment system (IPS) based upon costs with limits, tighter eligibility, and increased scrutiny from the Office of Inspector General.
- In 2000, the prospective payment system replaced the IPS. At the same time, eligibility for the benefit was broadened slightly. Enforcement of the Medicare program's integrity standards continue at the regional home health intermediaries and survey and certification unites.
- More information on changes in home health spending can be found on the CMS website, available at <http://www.cms.hhs.gov/review/current.asp>.

Chart 9-11. Medicare home health care use, 1999–2000

Year	People served		Visits	
	Number (thousands)	Per 1,000 enrollees	Number (thousands)	Per person served
1992	2,506.2	70	132,220	53
1993	2,874.1	79	164,234	57
1994	3,179.2	93	208,621	66
1995	3,469.4	102	249,394	72
1996	3,599.7	107	264,798	74
1997	3,557.5	108	258,168	73
1998	3,061.6	95	155,407	51
1999	2,719.7	85	113,439	42
2000	2,461.2	75	90,566	37

Source: CMS, Office of the Actuary, December 2002.

- In the early 1990s, the rapid growth in home health use was a concern to policymakers. Between 1992 and 1996, the number of beneficiaries using home health care increased by more than one million. The total volume of home health was expanding rapidly as the number of visits per user increased along with the number of users.
- In the mid-1990s, the Congress required home health agencies to begin the transition to a prospective payment system, CMS clarified the standards of eligibility for the home health benefit, and the Office of Inspector General increased its scrutiny of home health. Between 1997 and 2000, the number of users fell by one million.
- Many measures of home health use are available at <http://www.cms.hhs.gov/providers/hha>.

Chart 9-12. Mix of home health visits changed after the prospective payment system started

Type of visit	Pre-PPS			Post-PPS	
	1997	1998	1999	2001	2002
Therapy	9%	11%	15%	25%	26%
Home health aide	49	42	35	24	23
Skilled nurse	41	45	48	50	51

Note: PPS (prospective payment system). The prospective payment system began in October 2000. Columns do not sum to 100 percent because data were not available for all visit types.

Source: Pre-PPS CMS analysis of the National Claims History file; post-PPS MedPAC analysis of 5 percent Standard Analytic File.

- The mix of visits (therapy, aide, or skilled visits as a percent of total visits provided during an episode) has shifted toward therapy (physical therapy, occupational therapy, and speech pathology) and away from home health aide services.
- An episode of home health care includes all of the visits and routine supplies that beneficiaries receive over a 60-day period. Beneficiaries can continue to receive episodes of home health care as long as they remain eligible for the benefit.
- The types and quantity of home health care services that beneficiaries receive are changing. In 1997, before the PPS, the average number of visits per episode was 36. By 2002, that had fallen to 21 visits. The average length of stay fell from 106 days in 1997 to 56 days in 2002.
- Information about the use of home health services after the PPS can be found on the official Medicare website, available at <http://www.medicare.gov>.

Chart 9-13. Freestanding home health agency Medicare margin, by type of agency, 2001, and estimated 2004

Type of agency	2001	2004
All agencies	16.2	16.8
Location of agency		
Urban	16.0	16.9
Rural	17.0	16.3
Caseload		
Urban	16.2	17.3
Mixed	15.3	15.1
Rural	18.7	17.8
Type of control		
Voluntary	15.0	15.6
Private	17.4	18.0
Government	10.7	11.3
Volume		
Very small (20 th percentile)	11.4	12.1
Small (20 th –40 th)	15.0	15.6
Medium (40 th –60 th)	14.8	15.4
Large (60 th –80 th)	17.9	18.5
Very large (80 th)	16.3	16.9

Note: Margins are the difference between Medicare's payments and costs, divided by payments.

Source: MedPAC analysis of Medicare Cost Report file from CMS.

- In 2001, 80 percent of agencies had positive margins. These estimated margins indicate that Medicare's payments are well above the costs of providing services to Medicare beneficiaries, for both rural and urban home health agencies (HHAs).
- These margins are for freestanding HHAs, which composed two-thirds of all HHAs in 2001. Home health agencies are also based in hospitals.
- More information on the adequacy of home health payments can be found in Chapter 3D of the MedPAC March 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3D.pdf.

Web links. Post-acute care

- Chapter 5 of the MedPAC June 2003 Report to the Congress provides information on post-acute care.

http://www.medpac.gov/publications/congressional_reports/June03_Ch5.pdf

Skilled nursing facilities

- Chapter 3C of the MedPAC March 2004 Report to the Congress, Chapter 2C of the MedPAC March 2003 Report to the Congress, and Chapter 2D of the MedPAC March 2002 Report to the Congress provide information on Medicare margins for skilled nursing facilities.

http://www.medpac.gov/publications/congressional_reports/June03_Ch5.pdf

http://www.medpac.gov/publications/congressional_reports/Mar03_Ch2C.pdf

http://www.medpac.gov/publications/congressional_reports/Mar02_Ch2D.pdf

- The official Medicare website provides information on the prospective payment system and other related issues.

<http://www.cms.hhs.gov/providers/snfpps>

Home health services

- Chapter 3D of the MedPAC March 2004 Report to the Congress provides information on home health services.

http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3D.pdf

- The official Medicare website provides information on the quality of home health care, and additional information on new policies, statistics, and research.

<http://www.cms.hhs.gov/providers/hha>

Rehabilitation hospitals and units

- CMS provides information on the inpatient rehabilitation facility prospective payment system.

<http://cms.hhs.gov/providers/irfpps>

Long-term care hospitals

- Chapter 5 of the MedPAC June 2004 Report to the Congress provides information on long-term care hospitals.

http://www.medpac.gov/publications/congressional_reports/June04_ch5.pdf

- CMS also provides information on long-term care hospitals, including the long-term care hospital prospective payment system.

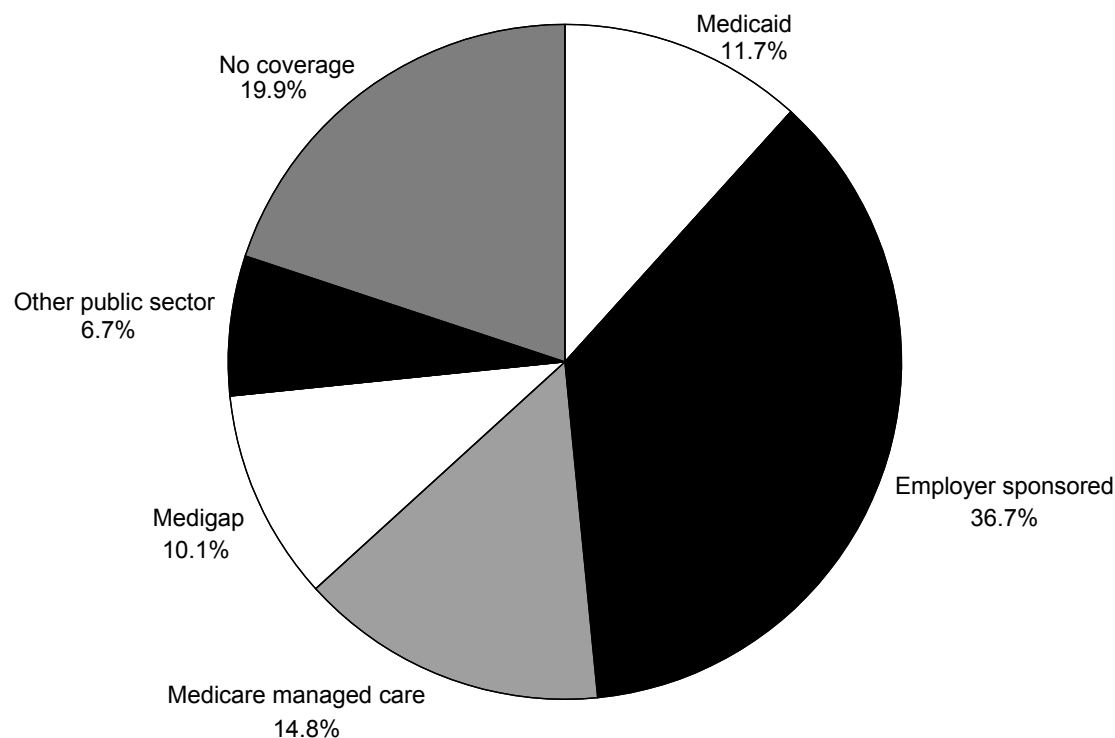
<http://cms.hhs.gov/providers/longterm>

S E C T I O N

10

Drugs

Chart 10-1. Sources of outpatient prescription drug coverage among noninstitutionalized beneficiaries, 2001

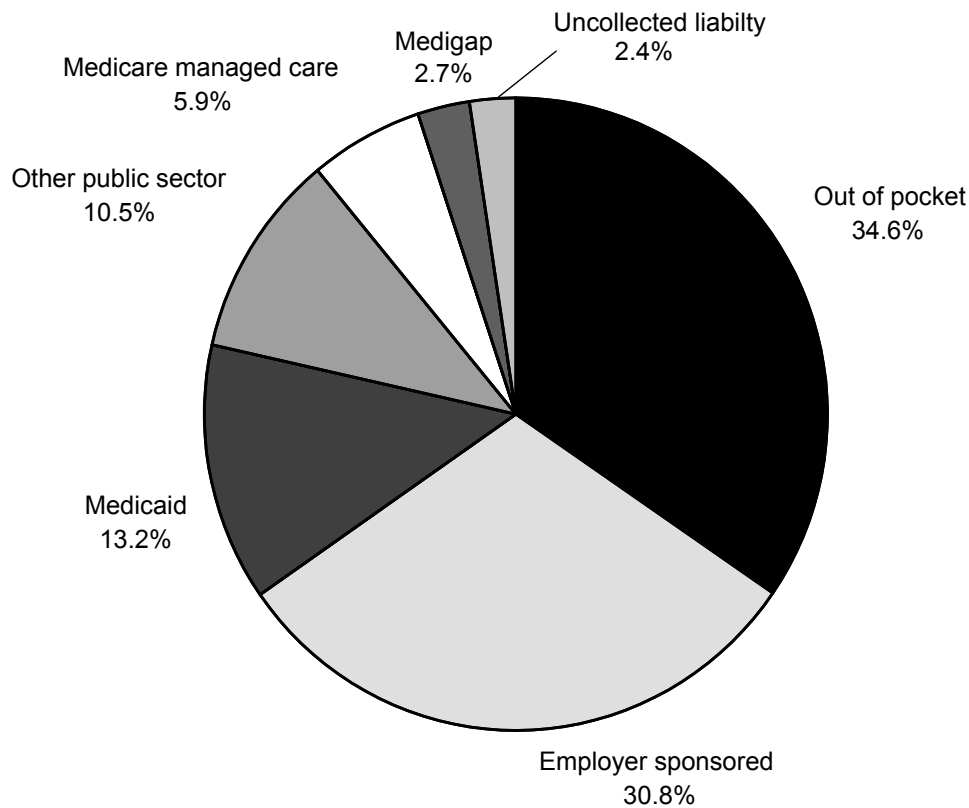


Note: Other public sector includes federal or state programs not included in the other categories. Analysis includes only beneficiaries living in the community. Totals may not sum to 100 due to rounding.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2001.

- Most beneficiaries living in the community have some drug coverage at some point over a calendar year. Twenty percent did not have any drug coverage at any time in 2001. The most common source of drug coverage in 2001 was employer-sponsored retiree coverage, held by 36.7 percent of community-dwelling beneficiaries. The sources of drug coverage may change substantially when the voluntary prescription drug program established under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 begins in 2006.
- The nature and generosity of coverage varies by source. Medicaid coverage is generally comprehensive and usually requires little cost sharing. Employer-sponsored coverage often provides relatively generous coverage, but the level of generosity has been declining in recent years and that trend is expected to continue. Medicare managed care coverage often has annual limits on the dollar amount of benefits and is generally less generous than Medicaid and employer-sponsored coverage. Also, the generosity of coverage varies substantially among managed care plans, but this variation will likely decline when the program begins making payments in 2006 to managed care plans that participate in the voluntary prescription drug program. Drug coverage through Medigap is relatively limited. All standard Medigap plans with drug coverage have a \$250 deductible, a 50 percent coinsurance rate, and have an annual limit on benefits of \$1,250 or \$3,000, depending on the plan.

Chart 10-2. Sources of payment for prescription drugs among noninstitutionalized beneficiaries, 2001

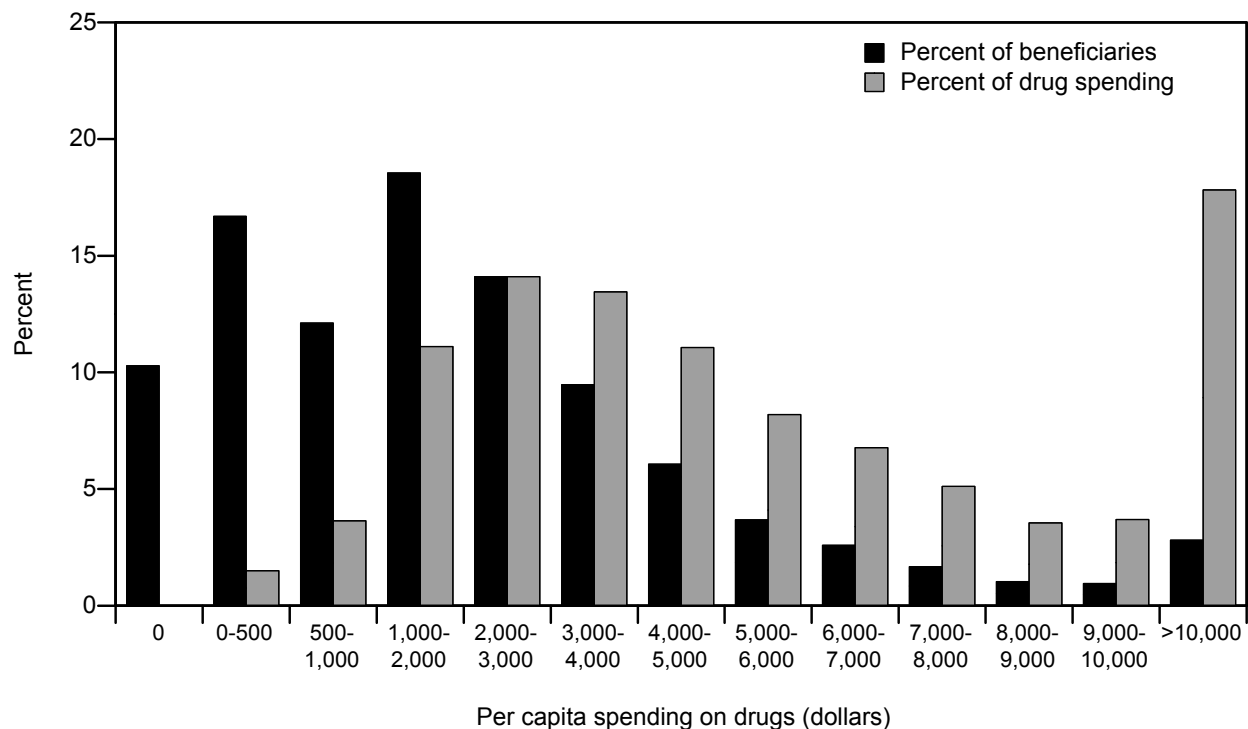


Note: Other public sector includes federal or state programs not included in the other categories. Analysis includes only beneficiaries living in the community.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2001.

- Beneficiaries living in the community have many sources paying for prescription drugs. The largest source of payment is beneficiaries' out-of-pocket spending, comprising 35 percent of total drug spending. The second-largest source of payment is employer-sponsored retiree coverage, which pays 31 percent of total drug spending.

Chart 10-3. Prescription drug spending per beneficiary, 2004



Source: Estimates from the Congressional Budget Office using data from Medicare Current Beneficiary Survey, 2000, projected to 2004.

- The level of spending on prescription drugs varies widely across beneficiaries.
- About 37 percent of drug spending is concentrated among the beneficiaries with at least \$6,000 in drug spending, but they are only 9 percent of all beneficiaries.
- About 30 percent of drug spending is concentrated among the 72 percent of beneficiaries with less than \$3,000 in drug spending.

Chart 10-4. Drug coverage among noninstitutionalized beneficiaries, by beneficiaries' characteristics, 2001

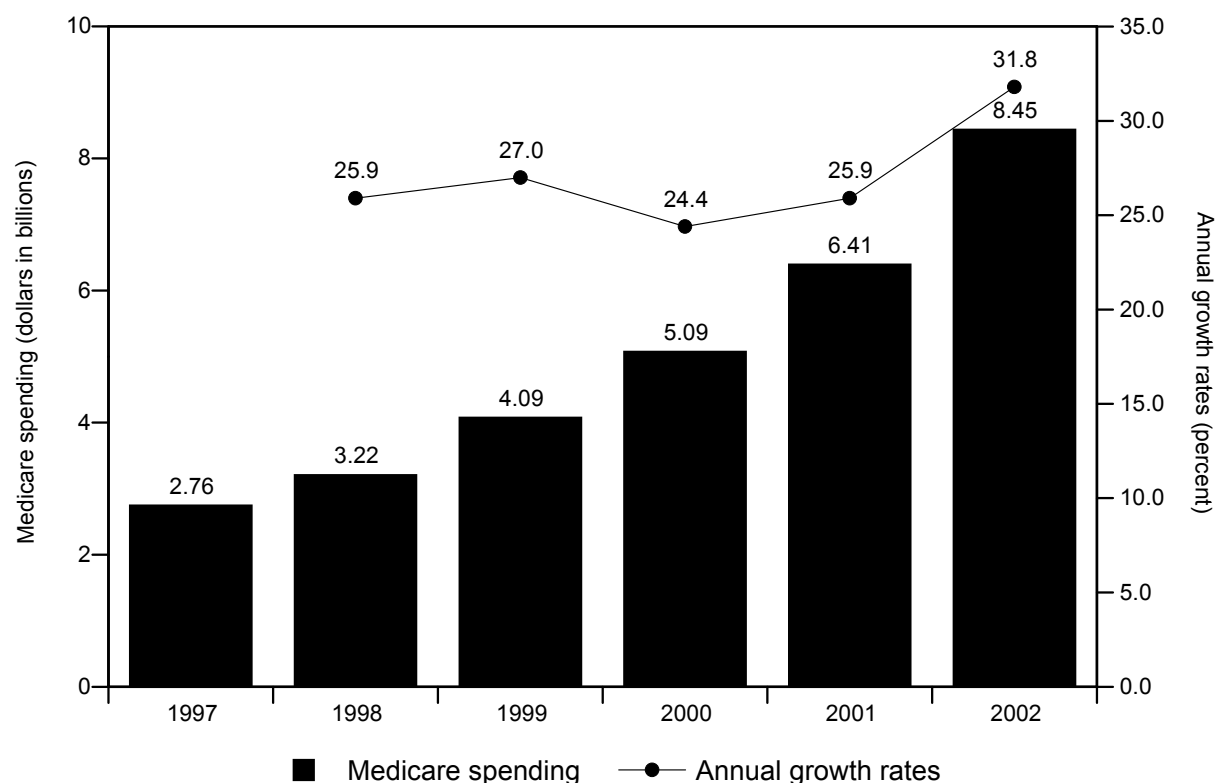
	Number of beneficiaries	Percent without drug coverage
All beneficiaries	38,508	19.9%
Age		
< 65	5,304	19.1
65–69	9,228	18.0
70–74	8,439	18.9
75–79	7,182	20.2
80–84	4,808	21.5
85+	3,547	26.0
Income status		
Below poverty	5,911	19.2
100–125% of poverty	3,966	25.6
125–200% of poverty	7,772	24.2
200–400% of poverty	11,570	18.9
Over 400% of poverty	9,175	15.6
Health status		
Excellent/very good	15,591	21.1
Good/fair	19,235	19.4
Poor	3,521	16.5
Race/ethnicity		
Hispanic	2,847	18.1
African American	3,588	19.8
White	30,562	20.2
Other	1,511	17.3
Residence		
Urban	29,315	17.1
Rural	9,168	34.7
Sex		
Male	17,148	19.9
Female	21,360	19.9

Note: Analysis includes only beneficiaries living in the community. In 2001, poverty was defined as \$8,494 for people living alone and \$10,715 for married couples. Totals may not sum due to rounding.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2001.

- Drug coverage among beneficiaries living in the community differs by demographic characteristics. Rural beneficiaries are much more likely to lack coverage than their urban counterparts. Other characteristics associated with lack of coverage include being age 85 or older and having income between 100 and 200 percent of poverty.

Chart 10-5. Medicare spending and annual growth rates for Part B drugs



Source: MedPAC analysis of unpublished CMS data.

- CMS estimates that expenditures for Part B drugs totaled \$8.45 billion in 2002, an increase of 32 percent over 2001.
- These totals do not include drugs provided through outpatient departments of hospitals or for end-stage renal disease patients in dialysis facilities. MedPAC estimates that in 2002 freestanding dialysis facilities alone billed Medicare an additional \$2.8 billion for drugs.
- The primary reason for growth in these expenditures is the increased volume of drugs used and the substitution of newer and more expensive medications for older therapies.
- Further analysis can be found in Chapter 9 of the MedPAC 2003 June Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/June03_Ch9.pdf.

Chart 10-6. Top 10 drugs covered by Medicare Part B, by share of expenditures, 2002

Name	Clinical indicators	Type of competition	Date of FDA approval	Percent of Part B drug spending
Non-ESRD epoetin alpha injections	Anemia	Multisource biological	1989	12.8%
Leuprolide acetate suspension	Prostate cancer	Multisource	1985	8.6
Ipratropium bromide	Asthma and other lung conditions	Generic	1993	7.1
Goserelin acetate implant	Prostate cancer	Sole source	1989	5.6
Drugs, unclassified injections	N/A	N/A	N/A	5.0
Albuterol	Asthma and other lung conditions	Generic	1982	5.0
Rituximab	Non-Hodgkin's lymphoma	Sole source biological	1997	4.9
Infliximab	Rheumatoid arthritis; Crohn's disease	Sole source biological	1999	4.0
Paclitaxel injection*	Cancer	Multisource	1992	2.9
Docotaxel	Cancer	Sole source	1996	2.5

Note: ESRD (end-stage renal disease), FDA (Food and Drug Administration).

*Generic equivalents are now available.

Source: MedPAC analysis of 2002 Medicare claims data from CMS and unpublished FDA data.

- Medicare covers about 450 outpatient drugs, but spending is very concentrated. The top 10 drugs account for almost 60 percent of all Part B drug spending.
- New drugs are replacing older drugs. Of the top 10 drugs covered by Medicare in 2002, 3 received Food and Drug Administration approval in 1996 or later. In addition, spending on injectibles too new to have received their own payment codes accounted for 5 percent of all Part B drug spending.
- Treatments for cancer dominate the list—11 of the top 15 drugs treat cancer or the side-effects associated with chemotherapy.

Web links. Drugs

- Chapter 9 of the MedPAC June 2003 Report to the Congress provides information on Medicare payments for outpatient drugs under Part B.

http://www.medpac.gov/publications/congressional_reports/June03_Ch9.pdf

- Fact sheet, last updated in May 2003, provides trend data for prescription drug coverage, expenditures, and the key factors that contribute to rising prescription drug spending.

<http://www.kff.org/rxdrugs/3057-03-index.cfm>

S E C T I O N

11

Other services

Dialysis

Hospice

Durable medical equipment

Chart 11-1. Total number of dialysis facilities is growing; for profit and freestanding are a higher share over time

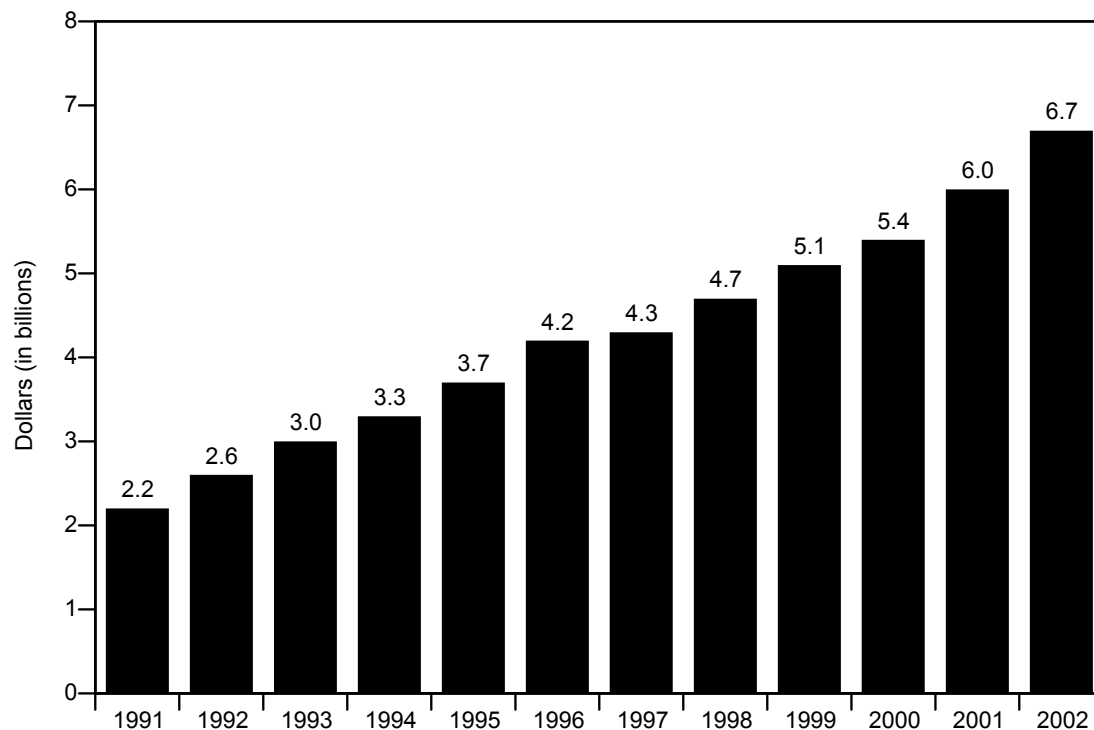
	1993		1995		1997		1999		2002		1993–2001
	Providers	%	Providers	%	Providers	%	Providers	%	Providers	%	Annual percent change
Total	2,343	100%	2,732	100%	3,172	100%	3,619	100%	4,132	100%	6.5%
For profit	1,424	61	1,766	65	2,255	71	2,796	77	3,279	80	9.7
Nonprofit	919	39	859	35	917	29	823	23	847	21	–0.9
Freestanding	1,640	70	2,013	74	2,441	77	2,920	81	3,438	83	8.6
Hospital based	703	30	719	26	731	23	699	19	694	17	–0.1
Urban, in an MSA	1,812	77	2,098	77	2,398	76	2,718	75	3,098	75	6.1
Rural	531	23	634	23	774	24	601	25	1,034	25	7.7

Note: MSA (metropolitan statistical area). Numbers may not sum due to rounding.

Source: Compiled by MedPAC from the 1993–2001 facility survey from CMS.

- Between 1993 and 2002, the number of freestanding and for-profit facilities increased and hospital-based and nonprofit facilities decreased. Freestanding facilities increased from 70 to 83 percent of all facilities, and for-profit facilities increased from 61 to 80 percent of all facilities.
- During this time, the proportion of facilities located in rural areas has remained relatively constant.
- Specific information about each dialysis facility can be found on the CMS website, available at <http://www.medicare.gov/Dialysis/Home.asp>.

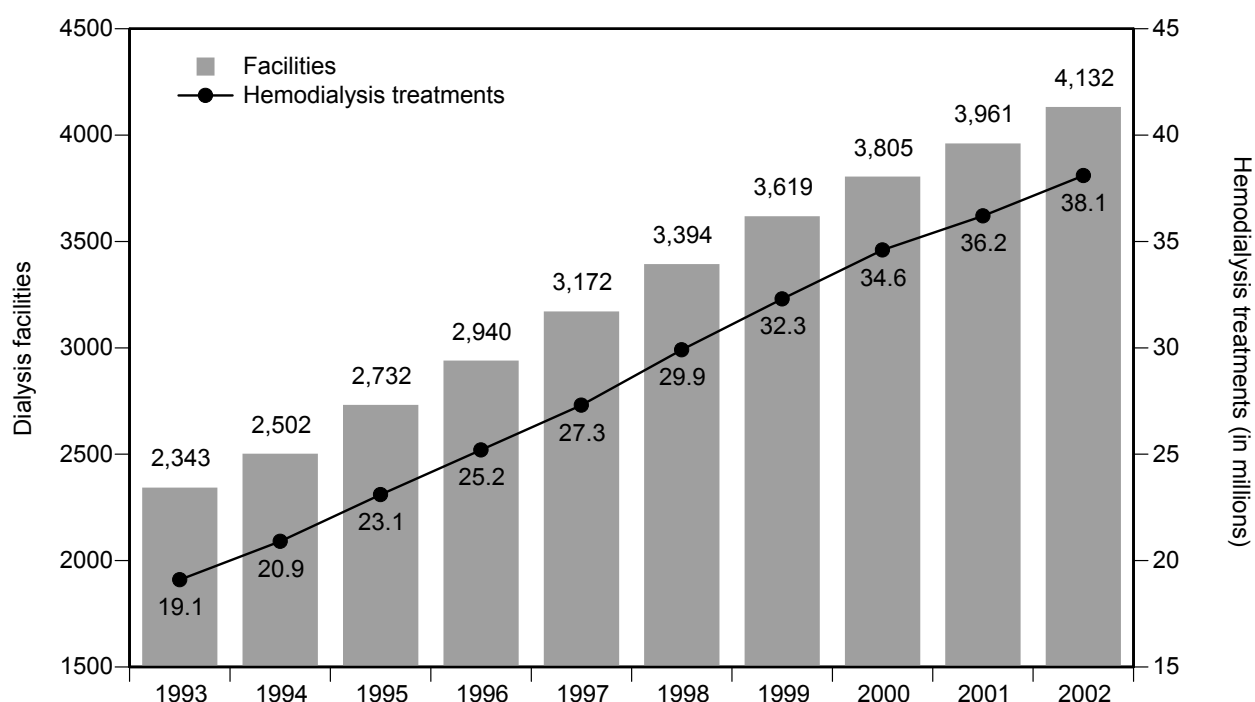
Chart 11-2. Medicare spending for outpatient dialysis services furnished by freestanding dialysis facilities, 1991–2002



Source: CMS, Office of the Actuary, 2004.

- Between 1991 and 2002, Medicare spending for both dialysis treatments (for which providers are paid a predetermined rate) and for injectable drugs administered during treatments (for which providers are paid on a per-unit basis) increased by about 11 percent per year.
- Two factors contributing to spending growth are the increasing size of the dialysis population and the diffusion of new technologies.
- The number of dialysis patients increased by 6 percent annually between 1996 and 2002. This growth is linked to a number of factors, including improvements in survival as well as increases in the number of people with diabetes, a risk factor for end-stage renal disease.
- New technologies—particularly injectable drugs such as erythropoietin, iron supplements, and vitamin D analogues—have also contributed to the growth in spending.
- Between 1996 and 2002, estimated spending for injectable drugs increased by 17 percent annually; in contrast, spending for dialysis increased by 6 percent annually.

Chart 11-3. Dialysis facilities' capacity has increased steadily between 1998 and 2002



Source: Compiled by MedPAC from the 1993–2002 facility file from CMS.

- Providers have met the demand for furnishing care to an increasing number of dialysis patients by opening new facilities. In 2002, a facility provided over 9,000 treatments on average.
- Between 1993 and 2002, the total number of dialysis facilities grew by about 6.5 percent annually, and the number of hemodialysis treatments grew by 8 percent annually.
- Specific information about each dialysis facility can be found on the CMS website, available at <http://www.medicare.gov/Dialysis/Home.asp>.

Chart 11-4 A disproportionate number of dialysis facilities that closed were small, nonprofit, and hospital based

Characteristics of facilities	Between 1998 and 2002	
	Opened facilities	Closed facilities
Mean number of hemodialysis stations	17.2	12.8
Percent of all facilities:		
Nonprofit	20%	43%
Hospital based	17	49
Rural	26	28
In HPSAs	10	10
Percent of households receiving public assistance	22	22
Percent of population that were African American	15	15

Note: HPSA (health professional shortage area).

Source: Compiled by MedPAC from the 1998–2002 Facility Survey file from CMS and from the Bureau of the Census.

- Between 1998 and 2002, there was a net increase of 738 dialysis facilities. Of the facilities that closed during this time, a disproportionate number of them were small, nonprofit, and hospital based. This finding is consistent with the changes in the characteristics of dialysis facilities in the 1990s and through 2002.
- Because closures were not disproportionately in these areas, beneficiaries should not be having problems accessing care in rural areas, health professional shortage areas, lower-income areas, or areas where a higher proportion of minorities reside.

Chart 11-5. The quality of dialysis care has improved for some measures

Outcome measure	1998	1999	2000	2001
Percent of in-center hemodialysis patients:				
Receiving inadequate dialysis	20	16	14	11
With low anemia levels	41	32	26	24
Who are malnourished	18	20	20	18
Dialyzed with an AV fistula	26	27	30	31
Percent of peritoneal patients:				
Receiving inadequate CAPD	45	32	31	32
Receiving inadequate CCPD	42	35	38	30
With low anemia levels	38	31	27	24
Who are malnourished	41	44	44	39

Note: AV (arteriovenous), CAPD (continuous ambulatory peritoneal dialysis), CCPD (continuous cycler-assisted peritoneal dialysis). The two predominant types of peritoneal dialysis are CAPD and CCPD. The share of all dialysis patients treated with peritoneal dialysis has declined from 13 to 10 percent between 1998 and 2001; nearly all other dialysis patients were treated with in-center hemodialysis during this time. Comparing the outcomes between hemodialysis and peritoneal dialysis is complicated because the data presented above are not adjusted for differences in the demographic and clinical characteristics of these patient groups.

Source: 1999–2002 Annual Report for ESRD Clinical Performance Measures Project from CMS.

- The quality of dialysis care has improved for some measures. Between 1998 and 2001, the proportion of both hemodialysis and peritoneal patients receiving inadequate dialysis and having low anemia levels declined.
- Nutritional care is a clinical area in which substantial improvements in quality are needed. The proportion of hemodialysis and peritoneal dialysis patients who are malnourished has remained relatively constant during this time.
- All hemodialysis patients require vascular access—the site on the patient’s body where blood is removed and returned during dialysis. Vascular access care is another clinical area in which substantial improvements in quality are needed. Use of arteriovenous (AV) fistulas, considered the best type of vascular access, increased slightly from 26 to 31 percent of hemodialysis patients between 1998 and 2001. Clinical guidelines recommend that at least 40 percent of all hemodialysis patients have an AV fistula.
- More information about Medicare’s quality initiatives for dialysis care can be found on the CMS website, available at <http://www.cms.hhs.gov/esrd/3.asp>.

Chart 11-6. The ESRD population is growing; most patients undergo hemodialysis

	1993		1997		2001	
	Patients (thousands)	%	Patients (thousands)	%	Patients (thousands)	%
Total	241.6	100%	330.8	100%	406.1	100%
Dialysis	174.9	72	242.0	73	292.2	72
In-center hemodialysis	143.3	59	205.4	62	263.6	65
Home hemodialysis	0.7	<1	1.8	<1	1.1	<1
Peritoneal dialysis	26.5	11	28.4	9	24.7	6
Unknown	4.4	2	6.4	2	2.8	1
Functioning graft and kidney transplants	66.7	28	88.9	27	113.9	28

Note: ESRD (end-stage renal disease).

Source: Compiled by MedPAC from the United States Renal Data System.

- Persons with end-stage renal disease (ESRD) require either dialysis or a kidney transplant to maintain life. The total number of patients increased by 7 percent annually between 1993 and 2001.
- In hemodialysis, a patient's blood flows through a machine with a special filter that removes wastes and extra fluids. In peritoneal dialysis, the patient's blood is cleaned by using the lining of his or her abdomen as a filter. Peritoneal dialysis is usually performed in a patient's home.
- Most ESRD patients undergo hemodialysis administered in dialysis facilities three times a week. Hemodialysis use is growing and use of the two types of dialysis administered in patients' homes—peritoneal dialysis and home hemodialysis—is declining.
- Functioning graft patients are patients who have had a successful kidney transplant. Patients undergoing kidney transplant may receive either a living or a cadaveric kidney donation. Of the 15,331 kidney transplants performed in 2001, 40 percent of the kidneys were from living donors and 60 percent were from cadaver donors.
- This table includes both patients who are and are not Medicare eligible. In 2001, about 96 percent of dialysis patients were Medicare eligible; Medicare was the primary payer for about half of all kidney transplants.
- Information on the incidence and prevalence of patients with renal disease can be found on the US Renal Data System website, available at <http://www.usrds.org>.

Chart 11-7. Diabetics and the elderly are the fastest growing segments of the hemodialysis population

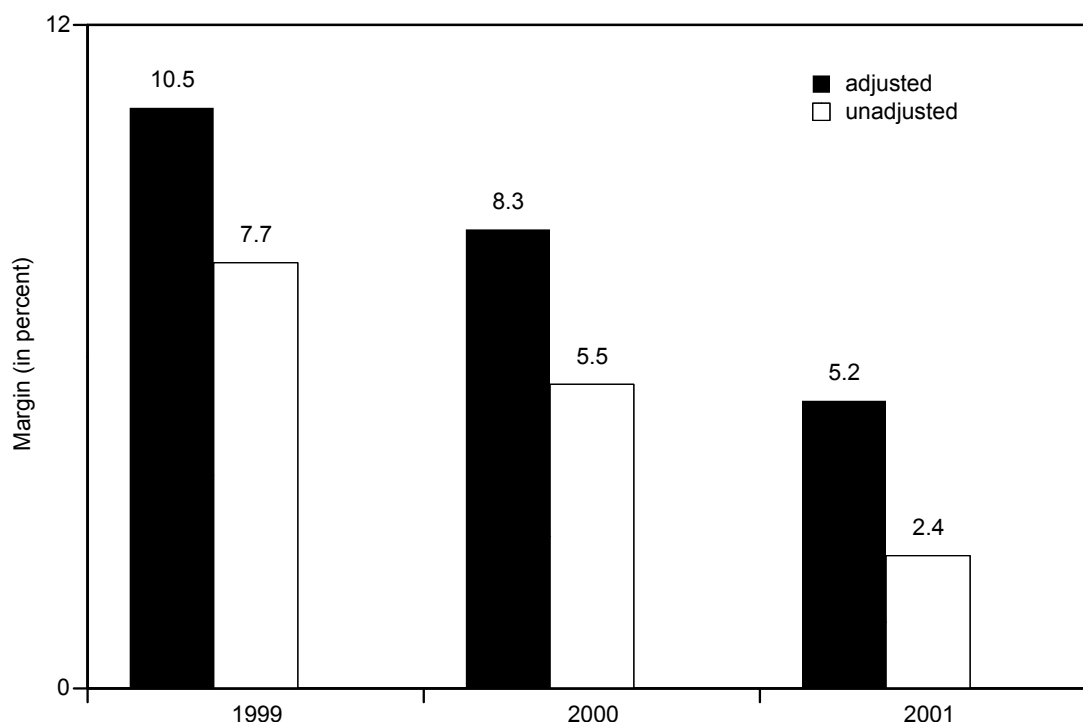
	Percent of total in 2001	Annual percent change 1996–2001
Total (264,710)	100%	6.8%
Age		
0–19	< 1	4.8
20–44	16	4.4
45–64	39	8.0
65–74	24	5.0
75+	21	9.2
Male	53	7.3
Female	47	6.3
White	54	7.5
African American	38	5.7
Native American	2	5.3
Other	6	9.4
Underlying cause of ESRD		
Diabetes	42	9.9
Hypertension	28	6.1
Glomerulonephritis	11	4.4
Other causes	20	3.7

Note: ESRD (end-stage renal disease). The above data include both Medicare-eligible and non-Medicare-eligible dialysis patients. In 2001, about 96 percent of dialysis patients were Medicare-eligible. Numbers may not sum due to rounding.

Source: Compiled by MedPAC from the United States Renal Data System, 2002.

- Among hemodialysis patients, about half are over age 65, male, and white.
- Diabetes is the most common cause of renal failure.
- The number of hemodialysis patients increased by about 7 percent annually between 1996 and 2001. The two fastest growing groups of hemodialysis patients are those who are over age 75 and those with diabetes as the cause of kidney failure.
- Information on the incidence and prevalence of patients with renal disease and their demographic and clinical characteristics can be found on the US Renal Data System website, available at <http://www.usrds.org>.

Chart 11-8. Medicare margin for outpatient dialysis services, adjusted and unadjusted, 1999–2001



Note: The Medicare margin includes payments and costs for both composite rate services and injectable drugs.

Source: MedPAC analysis of 1999–2001 cost report data and outpatient institutional claims of freestanding dialysis facilities from CMS.

- Payment relative to providers' cost declined between 1999 and 2001. The composite rate was updated 1.2 percent in 2000 and 2.4 percent in 2001. During this time, providers' costs for services in the composite rate bundle increased by 4.4 percent annually and the cost for the most frequently used injectable drug—erythropoietin—increased in 2000 and 2001, while the per unit payment rate remained unchanged.
- Nonetheless, in 2001, aggregate payments for both dialysis services and separately billable injectable drugs exceeded providers' costs by about 5 percent, after adjusting for the most recent audited cost report data, which shows that the allowable cost per treatment was about 96 percent of the costs reported by providers.
- More information about the financial performance of dialysis facilities can be found in Chapter 2E of the MedPAC March 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/Mar04_Ch2.pdf.

Chart 11-9. Lower costs per dialysis treatment do not result in quality problems for beneficiaries

Quality measure and quartile	URR>65%	HCT>33%	Mortality rate	Transplant rate
Composite rate costs only				
Q1	85%	70%	16%	2.2%
Q2	85	69	17	2.3
Q3	85	70	17	2.4
Q4	84	70	17	2.5
Both composite rate and injectable drug costs				
Q1	87	70	17	2.1
Q2	85	70	16	2.4
Q3	84	69	17	2.3
Q4	83	69	17	2.5

Note: Q (quartile), URR (urea reduction ratio), HCT (hematocrit). Lowest cost quartile is 1, highest is 4.

Source: Direct Research, LLC, from cost reports and Part B claims submitted by freestanding dialysis facilities for services furnished in 2000.

- Quality of care does not significantly differ between facilities with lower and higher costs for dialysis services included in the prospective payment bundle after adjusting for patient and facility characteristics.
- Considering both the costs for furnishing dialysis and separately billable drugs, beneficiaries' outcomes are poorer for facilities with higher than average costs after adjusting for patient and facility characteristics. One interpretation is that since drugs are currently paid on a per dose basis, some providers may not furnish these drugs as efficiently as if they were paid for prospectively. Alternatively, this finding may suggest that higher-cost facilities may be furnishing care to more medically complex beneficiaries.
- More information about the relationship between quality of care and providers' costs can be found in Chapter 6 of the MedPAC June 2003 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/June03_Ch6.pdf.

Chart 11-10. The number of freestanding and for-profit hospices has increased the most

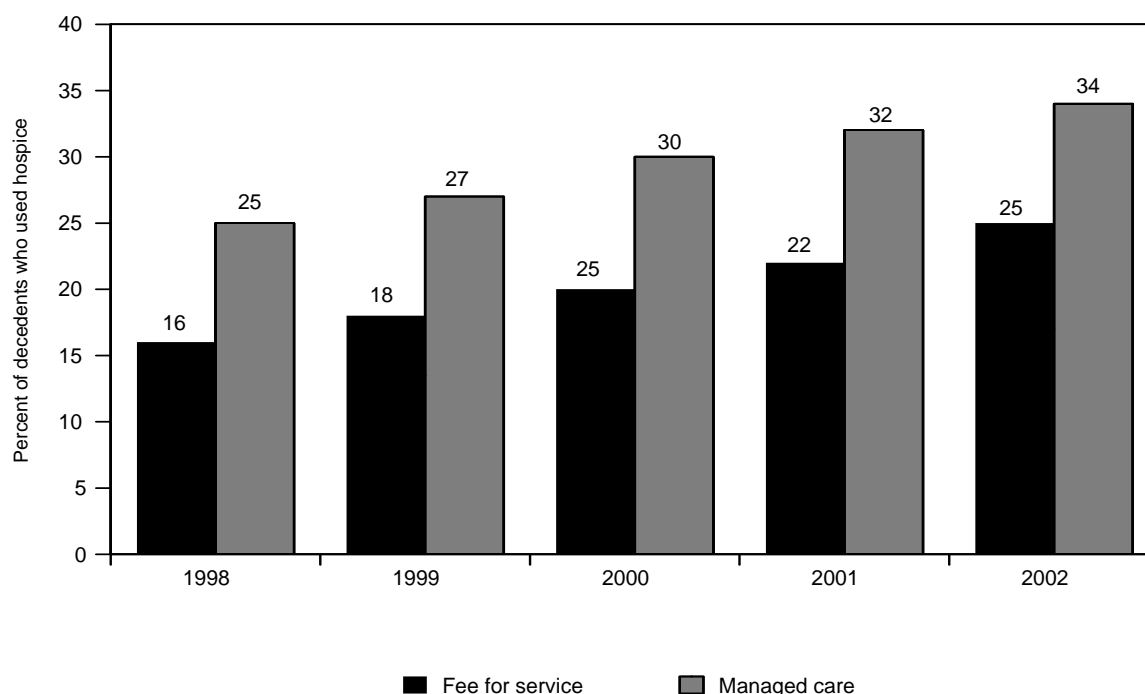
	Number of hospice facilities			Percent change 2001–2003
	2001	2002	2003	
All hospices	2,266	2,323	2,454	8%
Hospice type				
Freestanding	949	1,067	1,222	29
HHA based	744	677	653	–12
Hospital based	553	560	562	2
SNF based	20	19	19	–20
Ownership				
Not for profit	1,340	1,339	1,384	3
For profit	706	762	883	25
Government	187	188	189	1
Other	35	34	34	–3

Note: SNF (skilled nursing facility), HHA (home health agency).

Source: MedPAC analysis of unpublished data from CMS.

- The Medicare hospice benefit is specifically targeted to Medicare beneficiaries with a terminal illness. It covers a broad set of palliative services for beneficiaries whose physicians have determined that, if their illness runs a normal course, they have a life expectancy of six months or less. To elect the hospice benefit, beneficiaries must agree to forgo curative treatment for their terminal condition. The vast majority of hospice care is provided in patients' residences (i.e., their home or their nursing home).
- The number of hospices increased dramatically between 1992 and 1998 from 1,208 hospices to 2,281. Except for a decline in 2000 (when the number of home health agencies declined steeply), the number of hospice agencies has grown each year over the last decade.
- Hospice volume—measured by the hospice census—has also increased. Over the last several years, the number of high-volume hospices has grown, but the number of low-volume hospices has fallen.
- Between 2001 and 2003, the number of for-profit hospices increased considerably more than hospices with other types of ownership. Specifically, the number of for-profit hospices grew by 25 percent, while the number of not-for-profit and government hospices grew only 3 and 1 percent, respectively.
- Similarly the growth in freestanding hospices (not owned by another type of provider) from 2001–2003 has been much higher (29%) than other types (owned by home health agencies, hospitals and skilled nursing facilities).
- Additional information and analysis related to the Medicare hospice benefit can be found in Chapter 6 of the MedPAC June 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/June04_ch6.pdf.

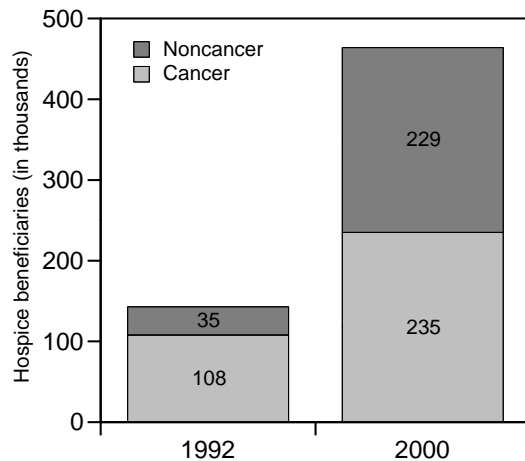
Chart 11-11. Hospice use has grown and remains higher for decedents in managed care



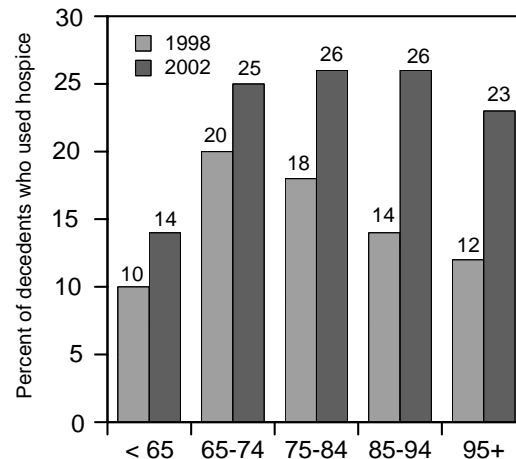
Source: MedPAC analysis of 5 percent enrollee database from CMS, 2003.

- From 1998 to 2002, the total percentage of beneficiaries using hospice in the year before they died grew from 20 percent to 26 percent. Beneficiaries in managed care are more likely to use hospice care than beneficiaries in the fee-for-service program. Between 1998 and 2002, the percentage of beneficiaries who used hospice before they died grew from 25 percent to 34 percent in managed care, and from 16 percent to 25 percent in fee-for-service.
- Additional information and analysis related to the Medicare hospice benefit can be found in Chapter 6 of the MedPAC June 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/June04_ch6.pdf.

Chart 11-12. Growth in hospice use is greatest among beneficiaries with noncancer diagnoses and those who are older



Source: Direct Research, LLC.

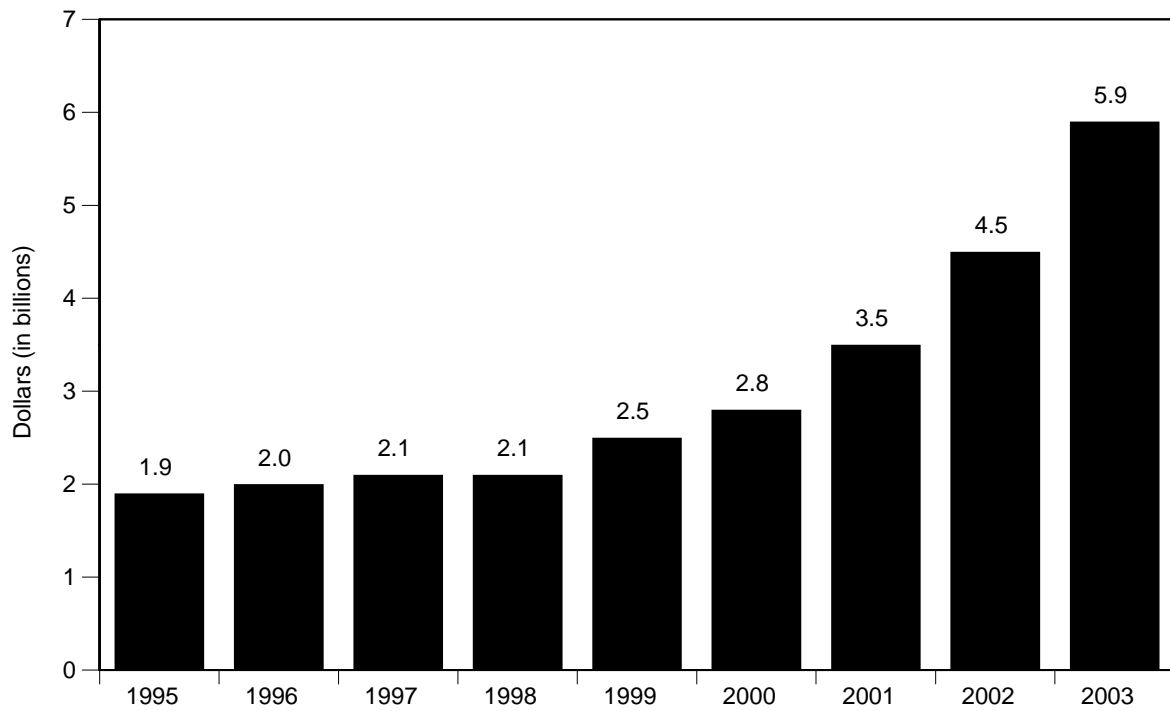


Note: Excludes beneficiaries in managed care.

Source: MedPAC analysis of 5 percent enrollee database from CMS, 2003.

- Growth in the use of hospice has occurred among beneficiaries in all age, race, and sex groups.
- Growth in hospice use has been fastest among older Medicare decedents. Between 1998 and 2002, the share of beneficiaries age 95 or older who died while in hospice care rose from 12 percent to 23 percent.
- The growing use of hospice by the oldest Medicare decedents is consistent with findings that hospice use has increased considerably among decedents in nursing facilities. From 1992 to 2000, use of hospice by decedents in nursing facilities grew from 11 percent to 36 percent.
- The share of hospice patients with noncancer diagnoses has grown to be about half the hospice population. The three most common noncancer diagnoses for hospice patients are congestive heart failure, dementia, and lung disease.
- Additional information and analysis related to the Medicare hospice benefit can be found in Chapter 6 of the MedPAC June 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/June04_ch6.pdf.

Chart 11-13. Recently, Medicare spending for hospice services has increased sharply



Source: CMS Office of the Actuary.

- Consistent with increases in the number of hospice users, Medicare spending for hospice care has increased. Spending has grown from an estimated \$3.5 billion in 2001 to \$5.9 billion in 2003—a 30 percent average annual increase.
- Medicare makes daily (per diem) payments to hospice agencies for each day a beneficiary is enrolled in the hospice benefit. Payments are made through a fee schedule with four different levels of care: routine home care, continuous home care, inpatient respite care, or general inpatient care. The majority of care—95 percent—is provided at the routine home care level.

Chart 11-14. Median stays remain stable while long stays grow rapidly

	Length of stay (in days)			
	Mean	25 th percentile	Median	90 th percentile
1998	52	6	18	123
1999	51	6	17	129
2000	51	6	16	130
2001	50	6	16	133
2002	55	5	16	147

Source: MedPAC analysis of 5 percent enrollee database from CMS, 2003.

- In most cases, a beneficiary's length of enrollment in hospice is determined by the number of days a beneficiary lives after electing the hospice benefit.
- Between 2001 and 2002, the average length of enrollment for a beneficiary in hospice care increased from 50 days to 55 days, but the median remained 16 days.
- A consistent subset of the hospice population has short lengths of stay. From 1998 to 2002, more than 25 percent of hospice beneficiaries were enrolled in hospice for less than a week.
- Long stays are getting longer. The length of stay at the 90th percentile has steadily increased. The increased prevalence of nursing home residents in the hospice population may be a factor in this long-stay trend.
- Additional information and analysis related to the Medicare hospice benefit can be found in Chapter 6 of the MedPAC June 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/June04_ch6.pdf.

Chart 11-15. Program payments are growing rapidly for durable medical equipment

	2000	2001	2002	2000–2002
Category	Payment (millions)	Payment (millions)	Payment (millions)	% change in payments
Total	\$4,629	\$5,417	\$6,480	40%
Medical/surgical supplies	635	728	848	34
Hospital beds	340	364	380	12
Oxygen and supplies	1,392	1,543	1,734	25
Wheelchairs	619	792	1,121	81
Orthotic devices	615	739	877	43
Other	1,028	1,251	1,522	48

Note: Beneficiaries are responsible for a 20 percent copayment for durable medical equipment.

Source: MedPAC analysis of CMS data, May 5, 2003. Available at <http://www.cms.hhs.gov/data/betos/cy2001.asp>.

- Spending on durable medical equipment (DME) grew 40 percent between 2000 and 2002. The fastest growing categories are wheelchairs (81 percent) and other (48 percent). Other includes drugs used with DME, such as albuterol.
- Additional historic Medicare Part B physician and supplier data can be found on the CMS website, available at <http://www.cms.hhs.gov/data/betos>. Information on competitive bidding can be found at <http://www.cms.hhs.gov/healthplans/research/dmebid.asp> and http://www.medpac.gov/publications/congressional_reports/June03_Ch8.pdf.

Web links. Other services

Dialysis

- The US Renal Data System provides information about the incidence and prevalence of patients with renal disease, their demographic and clinical characteristics, and their spending patterns.

<http://www.usrds.org>

- The National Institute of Diabetes & Digestive & Kidney Diseases and the National Kidney Foundation provide health information about kidney disease for consumers.

<http://www.niddk.nih.gov/health/kidney/kidney.htm>

<http://www.kidney.org/>

- CMS provides specific information about each dialysis facility.

<http://www.medicare.gov/Dialysis/Home.asp>

- Chapter 2E of the MedPAC March 2004 Report to the Congress provides information about the financial performance of dialysis facilities.

http://www.medpac.gov/publications/congressional_reports/Mar04_Ch2.pdf

- MedPAC's October 2003 report describes how Medicare could modernize the outpatient dialysis payment system.

http://www.medpac.gov/publications/congressional_reports/oct2003_Dialysis.pdf

- MedPAC's comment on revisions to payment policies under the physician fee schedule for calendar year 2004, includes changes in how to pay for services furnished by nephrologists.

http://www.medpac.gov/publications/other_reports/100603_RevPhysFeeSched_CB_comment.pdf

Hospice

- Chapter 6 of the MedPAC June 2004 Report to the Congress: New approaches in Medicare reviews trends and policy issues for the Medicare hospice benefit.

http://www.medpac.gov/publications/congressional_reports/June04_ch6.pdf

- The MedPAC May 2002 Report to the Congress: Medicare beneficiaries' access to hospice provides information on beneficiaries' access to hospice care.

http://www.medpac.gov/publications/congressional_reports/may2002_HospiceAccess.pdf

- Chapter 7 of the MedPAC June 1999 Report to the Congress examines end-of-life care and makes policy recommendations.

http://www.medpac.gov/publications/congressional_reports/Jun99%20Ch7.pdf

Durable medical equipment

- Pages 30 and 31 of the March 2002 Report to the Congress provide information about the durable medical equipment benefit.

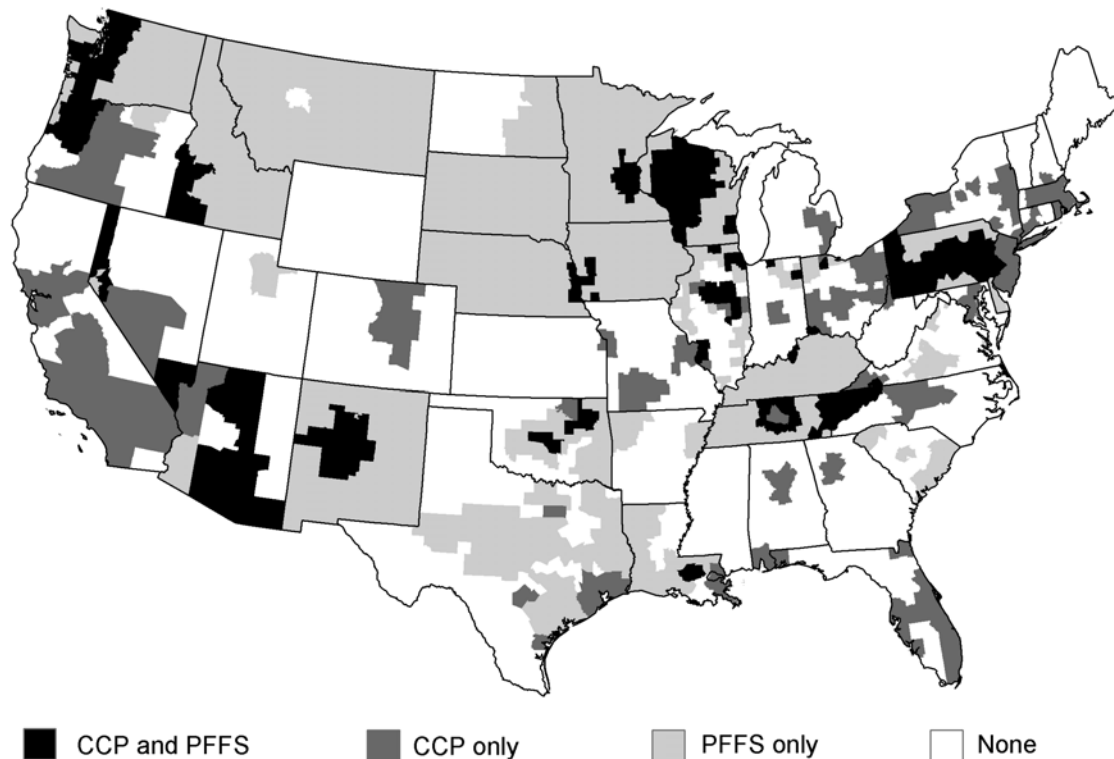
http://www.medpac.gov/publications/congressional_reports/Mar02_Ch1.pdf

SECTION

12

**Medicare+Choice and
Medicare Advantage**

Chart 12-1. Counties with M+C plans, 2004

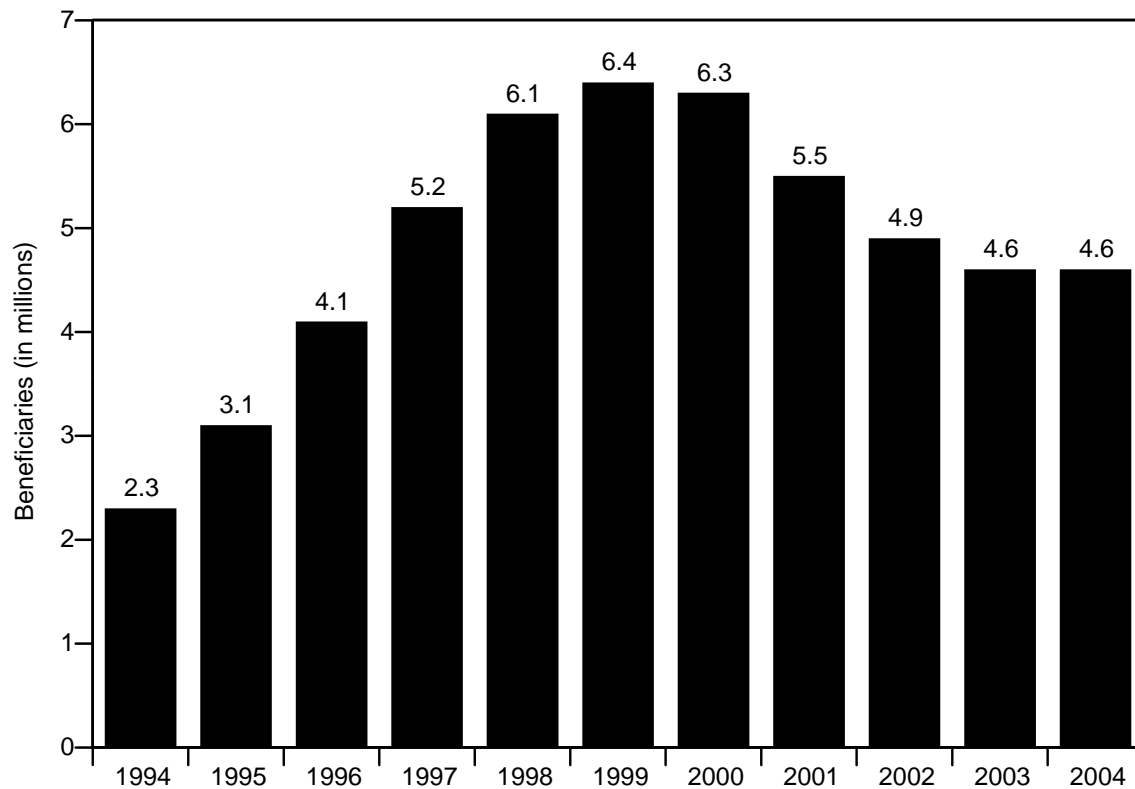


Note: M+C (Medicare+Choice), CCP (coordinated care plan), PFFS (private fee-for-service).

Source: Medicare Health Plan Compare database, February 2003. Available at <http://www.medicare.gov>.

- Coordinated care plans (CCPs) and private fee-for-service plans (PFFS) are the two types of Medicare+Choice (M+C)—now Medicare Advantage—plans. CCPs coordinate care for their members, while PFFS plans act as indemnity insurers.
- M+C plans are available in at least parts of 45 states. However, CCPs are available in only 38 states; 7 states with M+C plans have only PFFS plans available. Several states have CCPs available in a very limited area.

Chart 12-2. Enrollment in M+C plans, 1994–2004

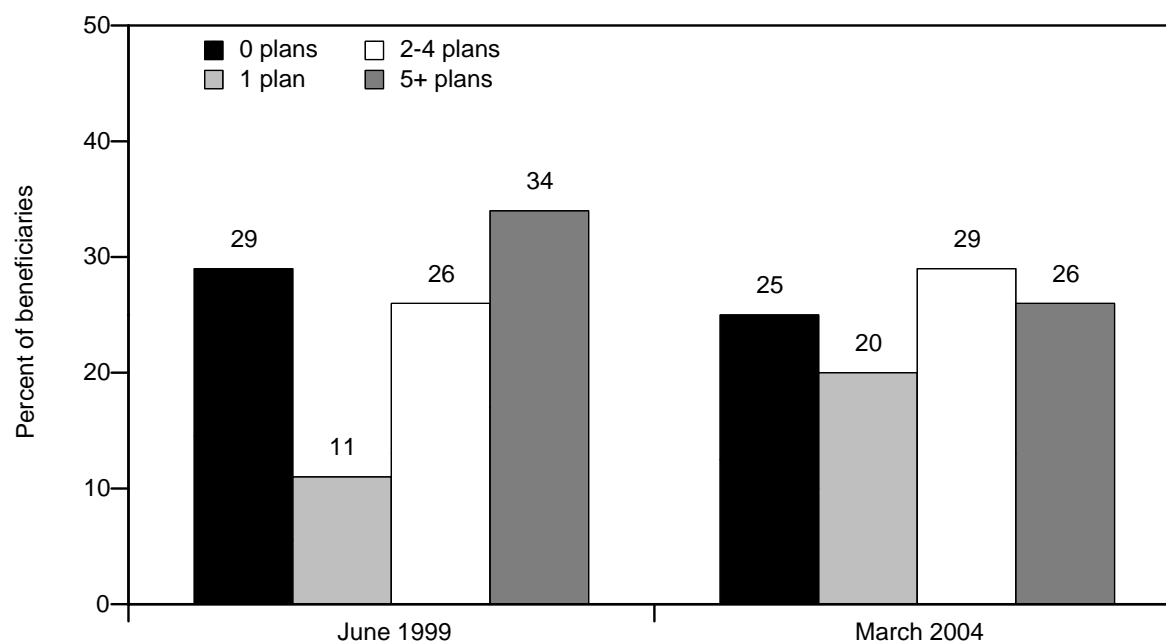


Note: M+C (Medicare+Choice).

Source: Medicare Managed Care Contract (MMCC) Plans, Monthly Summary Report, CMS. April 2003.
Available at <http://cms.hhs.gov/healthplans/statistics/mmcc>.

- Medicare enrollment in private health plans paid on an at-risk capitated basis rose rapidly throughout the 1990s, peaking at 6.4 million enrollees in 1999 (17 percent of all Medicare beneficiaries), and has since declined steadily to its current level of 4.6 million beneficiaries (12 percent of all Medicare beneficiaries).
- The current level of enrollment is approximately the same as it was just before the passage of the Balanced Budget Act of 1997 that created the Medicare+Choice—now Medicare Advantage—program. Previously, the plans were known as risk plans.

Chart 12-3. Medicare beneficiaries' access to M+C plans, 1999–2004

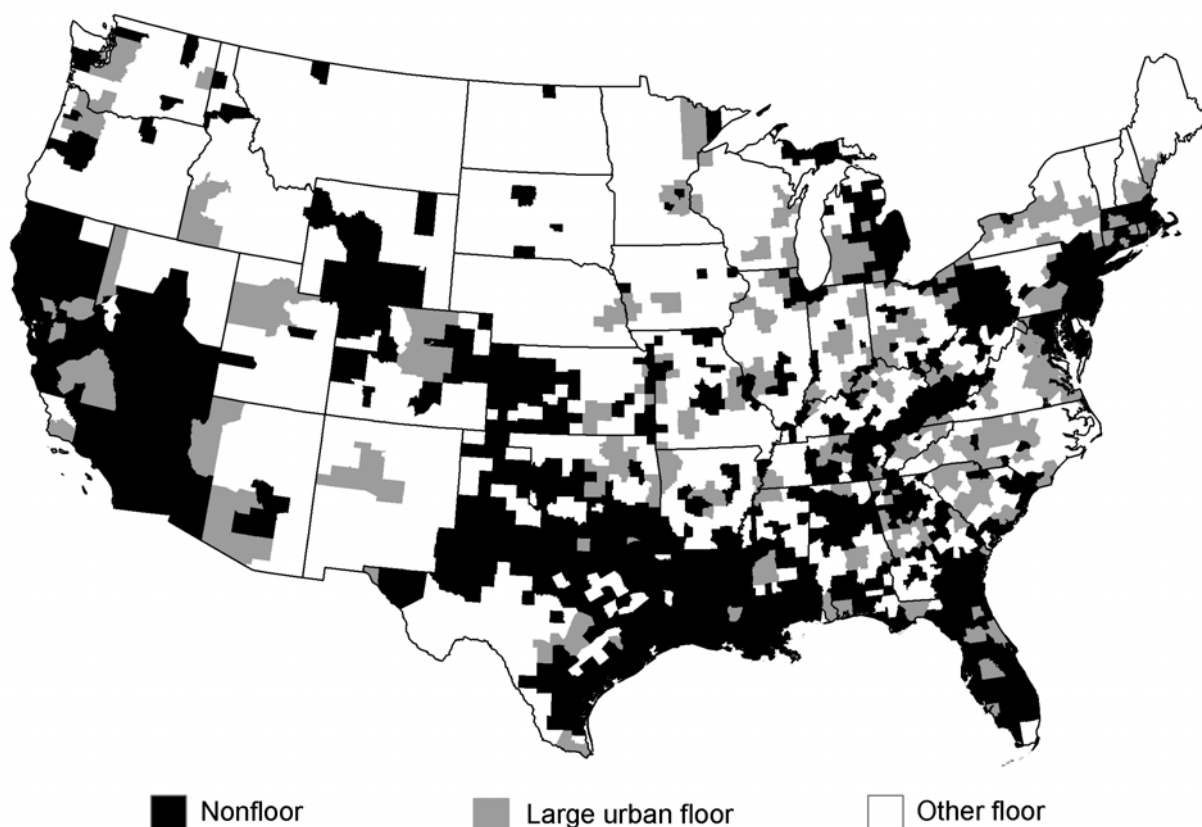


Note: M+C (Medicare+Choice). Area is defined as the county in which the beneficiary resides.

Source: MedPAC analysis of data from CMS.

- Between 1999 and 2004, the proportion of Medicare beneficiaries with access to at least one Medicare+Choice (M+C)—now Medicare Advantage—plan rose from 71 to 75 percent. The increase was due entirely to the introduction of the private fee-for-service (PFFS) plans, beginning in 2000. If the PFFS plans were excluded, the proportion of beneficiaries with access to an M+C plan would have declined to 61 percent in 2003.
- The proportion of beneficiaries with access to five or more plans declined from 34 percent in 1999 to 26 percent in 2004.

Chart 12-4. Counties, by M+C payment rates, 2004



Note: M+C (Medicare+Choice).

Source: MedPAC interpretation of CMS payment rate data for aged beneficiaries, December 2003.

- Medicare pays Medicare+Choice (M+C)—now Medicare Advantage—plans different rates in different counties. The Congress has set minimums, called floors, below which payment rates in any county may not fall. County rates are calculated based on a formula that includes factors involving historical Medicare spending and price indices. Counties here fall into one of three floor categories: (1) counties where the payment rates are high enough so that a floor does not affect them, (2) urban counties located within metropolitan areas that contain at least 250,000 beneficiaries whose rates would be lower if not for the “large urban” floor, and (3) other counties (in rural or less populated urban areas) for which rates would be lower if not for the “other” floor, which is set below the “large urban” floor.
- About 28 percent of all Medicare beneficiaries live in counties where a “large urban” floor determines the payment rates. Another 19 percent of beneficiaries live in other counties where a lower “other” floor determines payment rates. That leaves 53 percent of beneficiaries who live in counties where the rates were high enough so that they were not determined by a floor.
- M+C enrollees are distributed differently. While 26 percent of enrollees live in large urban floor counties, only 3 percent live in floor counties with the lower payment rate. Seventy-one percent of enrollees live in nonfloor counties.

Chart 12-5. Availability of M+C plans, 2004

	Percent of beneficiaries	M+C CCP	PFFS	Cost contracts	Any plan
National	100%	61%	31%	23%	77%
County payment rate					
Large urban floor	28	62	42	19	78
Other floor	19	22	41	12	57
"100% FFS"	37	71	22	19	82
Minimum update	12	85	24	48	89
Blend	4	78	4	60	81
Rural areas	23	16	40	9	51
Urban areas	77	75	28	27	85

Note: M+C (Medicare+Choice), CCP (coordinated care plan), PFFS (private fee-for-service). Totals may not sum due to rounding.

Source: MedPAC analysis of CMS data, April 2004. Available at <http://www.medicare.gov>.

- Under the Balanced Budget Act of 1997 and two subsequent acts, rates were the highest of three formula prongs: Fixed dollar amounts or "floors," a minimum guaranteed increase (2 percent) from prior year county rates, or a blend of local and national rates. Beginning in March 2004, a fourth prong was added to the formula—100 percent of the county's per capita fee-for-service spending.
- Eighty percent of Medicare beneficiaries have the option of joining a private plan to substitute for their traditional Medicare fee-for-service membership. Those who live in urban areas and areas with higher payment rates (rates higher than the other floor) are much more likely to have a plan available than the beneficiaries who reside in rural areas.
- When beneficiaries who live in rural areas have a plan available, that plan is most likely to be a private fee-for-service plan. In urban areas, the most widely available type of plan is the Medicare+Choice (M+C)—now Medicare Advantage—coordinated care plan. (Plans offered under cost contracts or the PPO demonstration program are similar to M+C plans, but the Medicare program pays them differently.)
- Further analysis can be found in Chapter 5 of the MedPAC March 2003 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/Mar03_Ch5.pdf

Chart 12-6. Counties, Medicare beneficiaries, and M+C enrollees, by the ratio of M+C payment rates to Medicare per beneficiary FFS spending in a county, 2004

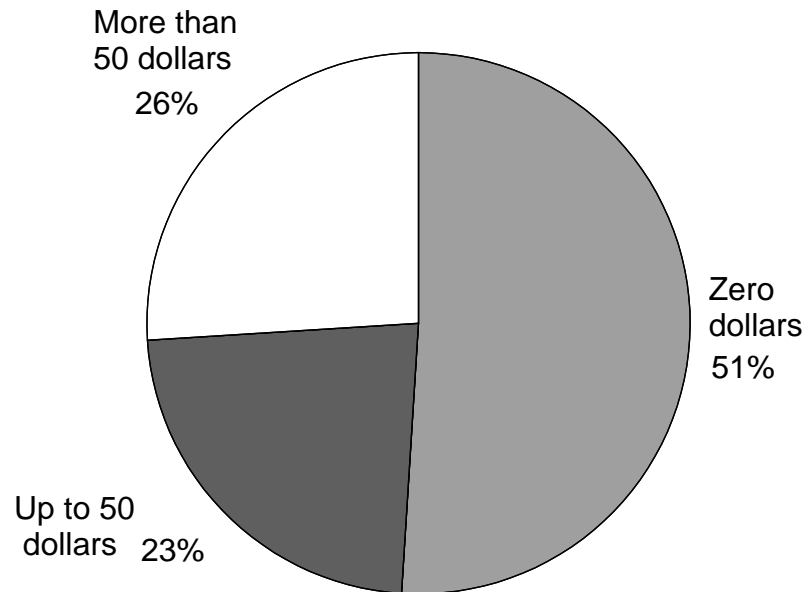
Ratio of M+C rates to FFS spending	Counties	Medicare beneficiaries	M+C enrollees
Total	100%	100%	100%
100–105	35	47	55
105–110	13	17	19
110–120	21	18	15
120+	31	18	12

Note: M+C (Medicare+Choice), FFS (fee-for-service).

Source: MedPAC analysis of Medicare county-level spending data and M+C payment rates from CMS, February 2003.

- Overall, the Medicare program pays more than the fee-for-service (FFS) cost for the current mix of Medicare+Choice (M+C)—now Medicare Advantage—enrollees, before accounting for risk differences. Further analysis can be found at: http://www.medpac.gov/publications/other_reports/April04_PostMMA_MplusC_2pgrSH.pdf.
- Most enrollees live in counties where the M+C payment rates are within 5 percent of average Medicare FFS spending per beneficiary (adjusted for demographic characteristics).

Chart 12-7. Lowest monthly premiums Medicare beneficiaries would have to pay to enroll in an available Medicare plan, 2004



Source: MedPAC analysis of CMS data, April 2004. Available at <http://www.medicare.gov>.

- Sixteen-and-a-half million beneficiaries (or 51 percent of beneficiaries with plans available) can enroll in zero-premium options. Of those beneficiaries, 3.5 million can enroll in zero-premium options that rebate between \$6.90 and the full \$66.60 Part B monthly premium.
- Almost half of beneficiaries with plans available have to pay a premium—in addition to the Part B premium—to enroll in any private plan option, and 26 percent would have to pay a monthly premium of \$50 or more.

Web links. Medicare+Choice and Medicare Advantage

- Chapter 5 of the MedPAC March 2003 Report to the Congress provides information on Medicare+Choice plans and other health insurance choices for Medicare beneficiaries.

http://www.medpac.gov/publications/congressional_reports/Mar03_Ch5.pdf

- CMS provides information on Medicare+Choice and other Medicare managed care plans.

<http://cms.hhs.gov/healthplans/>

- The official Medicare website provides information on plans available in specific areas and the benefits they offer.

<http://www.medicare.gov/mphCompare/home.asp>